No. 16-149

Title:	Coventry Health Care of Missouri, Inc., fka Group Health Plan, Inc., Petitioner v. Jodie Nevils
Docketed:	August 2, 2016
Lower Ct:	Supreme Court of Missouri
Case Nos.:	(SC93134)
Decision Date:	May 3, 2016

Questions Presented

~~Date~~~	~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~
Aug 1 2016	Petition for a writ of certiorari filed. (Response due September 1, 2016)
Aug 12 2016	Order extending time to file response to petition to and including October 3, 2016.
Oct 3 2016	Brief of respondent Jodie Nevils in opposition filed.
Oct 11 2016	Reply of petitioner Coventry Health Care of Missouri, Inc. filed.
Oct 12 2016	DISTRIBUTED for Conference of October 28, 2016.
Oct 31 2016	DISTRIBUTED for Conference of November 4, 2016.
Nov 4 2016	Petition GRANTED.
Dec 19 2016	Joint appendix filed. (Statement of costs filed)
Dec 19 2016	Brief of petitioner Coventry Health Care of Missouri, Inc. filed.
Dec 20 2016	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for petitioner
Dec 22 2016	SET FOR ARGUMENT on Wednesday, March 1, 2017.
Dec 27 2016	Brief amicus curiae of United States filed.
Dec 27 2016	Brief amicus curiae of The Chamber of Commerce of the United States of America filed.
Dec 27 2016	Brief amici curiae of America's Health Insurance Plans, et al. filed.
Jan 13 2017	Motion of the Acting Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
Jan 17 2017	Record requested from the Supreme Court of Missouri.
Jan 18 2017	CIRCULATED.
Jan 18 2017	Brief of respondent Jodie Nevils filed. (Distributed.)
Jan 19 2017	Record received from the Supreme Court of Missouri. The record is electronic.
Jan 24 2017	Brief amicus curiae of American Association for Justice filed. (Distributed)
Jan 25 2017	Brief amici curiae of National Governors Association, et al. filed. (Distributed)
Jan 25 2017	Brief amici curiae of Constitutional and Administrative Law Scholars filed. (Distributed)
Jan 25 2017	Brief amicus curiae of Missouri Association of Trial Attorneys filed. (Distributed)
Jan 25 2017	Brief amici curiae of Montana, et al. filed. (Distributed)
Feb 16 2017	Reply of petitioner Coventry Health Care of Missouri, Inc. filed. (Distributed)
Feb 17 2017	Motion of the Acting Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.

Mar 1 2017	Argued. For petitioner: Miguel A. Estrada, Washington, D. C.; and Zachary D. Tripp, Assistant to the Solicitor General, Department of Justice, Washington, D. C. (for United States, as amicus curiae.) For respondent: Matthew Wessler, Washington, D. C.
Apr 18 2017	Judgment REVERSED and case REMANDED. Ginsburg, J., delivered the opinion of the Court, in which all other Members joined, except Gorsuch, J., who took no part in the consideration or decision of the case. Thomas, J., filed a concurring opinion.
May 22 2017	JUDGMENT ISSUED.
May 22 2017	MANDATE ISSUED.

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No. 16-149

IN THE
Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of Missouri

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, governs the health benefits of millions of federal workers and dependents, and authorizes the Office of Personnel Management ("OPM") to enter into contracts with private insurance carriers to administer benefit plans. FEHBA expressly "preempt[s] any State or local law" that would prevent enforcement of "the terms of any contract" between OPM and a carrier which "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Id.* § 8902(m)(1). In a 2015 regulation, OPM codified its longstanding position that FEHBA-contract provisions requiring carriers to seek subrogation or reimbursement "relate to ... benefits" and "payments with respect to benefits," and therefore FEHBA preempts state laws that purport to prevent FEHBA insurance carriers from pursuing subrogation and reimbursement recoveries. 5 C.F.R. § 890.106(h). Expressly disagreeing with multiple federal circuits and state appellate courts, the Missouri Supreme Court nevertheless construed FEHBA not to preempt such state laws—explicitly refusing to accord any deference to OPM's regulation. A majority of the court further concluded that Section 8902(m)(1) violates the Supremacy Clause of the U.S. Constitution. The questions presented are:

1. Whether FEHBA preempts state laws that prevent carriers from seeking subrogation or reimbursement pursuant to their FEHBA contracts.

2. Whether FEHBA's express-preemption provision, 5 U.S.C. § 8902(m)(1), violates the Supremacy Clause.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

All parties to the proceeding are named in the caption.

Xerox Recovery Services, Inc. (formerly known as ACS Recovery Services, Inc.) intervened as an additional defendant in the case, but Xerox and Nevils subsequently settled the claims as between themselves. Xerox is no longer a party to this litigation and did not participate in the case in the Missouri Supreme Court on remand from this Court.

Pursuant to this Court's Rule 29.6, petitioner Coventry Health Care of Missouri, Inc. (formerly known as Group Health Plan, Inc.) is a wholly owned subsidiary of Aetna Health Holdings, LLC (successor by merger to Coventry Health Care, Inc.). Aetna Health Holdings, LLC, in turn, is a wholly owned subsidiary of Aetna Inc. Aetna Inc. is a publicly traded corporation that has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Coventry Health Care of Missouri, Inc. (formerly Group Health Plan, Inc.) respectfully petitions for a writ of certiorari to review the judgment of the Supreme Court of Missouri.

OPINIONS BELOW

The Missouri Supreme Court's opinion under review (Pet. App. 1a-14a) is not yet reported but is available at 2016 WL 3919334. That court's prior opinion (Pet. App. 44a-72a) is reported at 418 S.W.3d 451. The Missouri Court of Appeals' opinion (Pet. App. 33a-43a) is not reported but is available at 2012 WL 6689542. The Missouri Circuit Court's decision (Pet. App. 28a-32a) is not reported. The U.S. District Court for the Eastern District of Missouri's ruling remanding the case to state court (*id.* at 15a-27a) is not reported but is available at 2011 WL 8144366.

JURISDICTION

The Supreme Court of Missouri entered judgment on May 3, 2016, accompanied by an opinion adjudicating the federal questions presented here. This Court has jurisdiction under 28 U.S.C. § 1257(a). *See Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 476-87 (1975); *infra* pp. 36-37.

RULE 29.4(b) STATEMENT

The decision below calls into question the validity of 5 U.S.C. § 8902(m)(1). The United States was not a party in the state-court proceedings (but participated as *amicus* below and previously in this Court). Section 2403(a) of Title 28, United States Code, thus may now apply.

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS INVOLVED

Section 8902(m)(1) of Title 5, United States Code, provides:

> **§ 8902. Contracting authority**
>
> * * *
>
> (m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.
>
> * * *

Section 8913(a) of Title 5, United States Code, provides:

> **§ 8913. Regulations**
>
> (a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.
>
> * * *

Other pertinent constitutional, statutory, and regulatory provisions are reproduced in the Appendix at 75a-115a.

STATEMENT

For the second time in three years, the Missouri Supreme Court has held that States may nullify key terms of *federal* contracts—governed by a *federal* statute with a sweeping express-preemption provision, 5 U.S.C. § 8902(m)(1)—entered into by a *federal* agency to provide employee benefits for the *federal* workforce. The decision below solidifies two lower-court conflicts, holds a federal statute unconstitutional, and jeopardizes a massive, multibillion-dollar program that serves 8 million federal workers and dependents.

In 2014, the Missouri Supreme Court—directly contrary to decisions of the Eighth Circuit and Georgia Supreme Court, among others—held that the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, does not preempt state laws barring FEHBA carriers from seeking subrogation or reimbursement, even when required to do so by their FEHBA contracts with the Office of Personnel Management ("OPM"). Pet. App. 46a-54a. Coventry sought certiorari, and the United States (whose views this Court invited) agreed that the Missouri court's decision addressed an important federal question, split with other courts, and was "wrong and should be reversed." U.S. *Amicus* Br. 11-12, *Coventry Health Care of Mo., Inc.* v. *Nevils*, No. 13-1305 (U.S. May 22, 2015) ("U.S. Invitation Br."). At the government's suggestion, however, this Court gave the Missouri court a second chance, remanding for further consideration in light of a then-recent OPM regulation addressing the preemption issue, which the government hoped would steer the state court to "reach a different outcome" and resolve the split. *Id.* at 21; *see* 135 S. Ct. 2886 (2015).

That solution, regrettably, did not succeed. The split, in fact, has expanded and become entrenched, and the Missouri Supreme Court only exacerbated its errors. Since this Court's remand in this case, the Tenth Circuit and Arizona Court of Appeals have joined the Eighth Circuit—which has also reiterated its prior, pro-preemption interpretation—and the Georgia Supreme Court (among others) in rejecting the Missouri court's narrow view of FEHBA's preemptive scope. Indeed, FEHBA now has a different reach in Missouri in federal versus state courts.

Meanwhile, the Missouri Supreme Court strayed further from this Court's teaching. On remand, a five-judge majority not only declined to revisit the court's prior, erroneous reading of the statute, but also refused to accord any weight to OPM's reasonable position in its regulation—decreeing *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), categorically inapplicable to express-preemption provisions. And an even larger majority, creating a second lower-court conflict, held (in a precedential six-judge concurrence) that FEHBA's preemption provision is *unconstitutional*.

The need for definitive guidance is thus now even clearer. There is no prospect that the split will resolve itself. Even as more federal and state courts have rejected its reading of FEHBA, the Missouri Supreme Court has dug in, spurning the opportunity to reconsider its statutory interpretation. The court made clear, moreover, that it will not budge from its conclusion that *Chevron* never applies to express-preemption provisions unless told otherwise directly by this Court. This Court, in fact, has already rejected that misguided conclusion, but the Show-Me State insists on being shown again.

The Missouri Supreme Court's further holding striking down FEHBA's preemption provision *in toto* makes the need for intervention even more urgent. Left standing, the decision below will make operation of FEHBA plans in Missouri unworkable, inviting state law to trump *any* provision of OPM's contracts with FEHBA carriers, even those indisputably within FEHBA's preemption provision.

Both the Missouri Supreme Court's erroneous holdings and the splits they cement, regarding a nationwide program designed to operate seamlessly across state lines, cannot be allowed to persist. Congress enacted FEHBA's preemption clause precisely to prevent state laws from foisting inconsistent requirements on multi-State plans—recognizing that disuniformity increases the costs of administering FEHBA plans and unfairly forces federal workers in some States effectively to subsidize the benefits of those who live in others. Only this Court can restore uniformity and certainty to this critically important area of federal law.

The petition should be granted.

1. Congress enacted FEHBA in 1959, creating the Federal Employees Health Benefits Program (the "Program") to provide health-insurance benefits for the federal workforce. Congress sought to "assure maximum health benefits for [federal] employees at the lowest possible cost to themselves and to the Government." H.R. Rep. No. 86-957, at 4 (1959). Congress authorized OPM to administer the Program—including by issuing regulations, 5 U.S.C. § 8913(a), and by entering into contracts with private insurance carriers to administer FEHBA plans, *id.* § 8902(a).

Today, the FEHBA Program is "the largest employer-sponsored health benefits program in the United States." Press Release, OPM, *Open Season for Federal Health Benefits, Dental and Vision* (Sept. 29, 2015), http://tinyurl.com/hchvdub. It covers "[a]pproximately 85 percent of all Federal employees," *ibid.*—more than 8 million federal workers and dependents combined—and pays out tens of billions of dollars in benefits annually. OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29,203, 29,203 (May 21, 2015). The federal government (and ultimately the public) pays the lion's share of premiums (typically 72%)—more than $30 billion each year—and participants pay the remainder. *Ibid.*; 5 U.S.C. § 8906(b)(1).

2. In the 1970s, Congress became concerned about state regulation of FEHBA plans, which had "[i]ncreased premium costs to both the Government and enrollees" and introduced "[a] lack of uniformity of benefits" even "for enrollees in the same plan." H.R. Rep. No. 94-1211, at 3 (1976). "[E]nrollees in some States" were forced to pay "a premium based, in part, on the cost of benefits provided only to enrollees in *other* States." *Ibid.* (emphasis added). Congress responded in 1978 by enacting an express-preemption provision, which originally provided:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that

> such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1) (1994).

After decades of additional experience, Congress concluded that this provision did not go far enough. It accordingly amended Section 8902(m)(1) in 1998 to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997). The amendments broadened Section 8902(m)(1), by adding language to preempt state laws that frustrate FEHBA-contract terms that relate to the "provision" of coverage, benefits, or benefit payments, and by removing the proviso limiting preemption to state laws "inconsistent" with FEHBA contracts. Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (1998).

3. OPM's FEHBA contracts have long included provisions requiring carriers to seek subrogation and reimbursement. *E.g.*, Standard Contract for Community-Rated Health Maintenance Organization Carriers § 2.5 (2000), *available at* http://tinyurl.com/joeb6dc. Such provisions apply where a beneficiary receives federal benefits under her FEHBA plan, but also recovers, or has a right to recover, for the same injuries from a third party. If the beneficiary has not yet recovered from the third party, the carrier must seek to recover from that party directly. If the beneficiary has already recovered, the carrier must seek reimbursement from the beneficiary. OPM, *Proposed Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 931, 932 (Jan. 7, 2015).

OPM has understood Section 8902(m)(1) "since Congress enacted it in 1978" to preempt state laws that would otherwise bar FEHBA carriers from seeking subrogation or reimbursement. *Final Rule*, 80 Fed. Reg. at 29,204; Pet. App. 117a-18a. OPM's contracts thus generally provide that carriers' subrogation and reimbursement obligations apply regardless of whether state law otherwise bars subrogation or reimbursement, so long as the carrier subrogates for one or more private employee-benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* *See, e.g.*, Pet. App. 129a-30a. This ensures that FEHBA plans receive equal treatment with private-sector plans governed by ERISA, which this Court has held preempts state laws that preclude insurance administrators from seeking reimbursement. *See FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-60 (1990).

4. Respondent Jodie Nevils commenced this putative state-court class action against Coventry, challenging Coventry's pursuit of subrogation and reimbursement as contrary to Missouri law. Nevils, a federal employee and FEHBA-plan participant, was injured in a car accident, and Coventry paid for his care. Pet. App. 45a. Nevils obtained a settlement recovery from the third party responsible for his injuries. *Ibid.* Coventry's OPM contract "direct[ed] [it] to seek reimbursement or subrogation when an insured obtains a settlement or judgment against a tortfeasor for payment of medical expenses." *Ibid.*; *id.* at 129a-30a. Coventry accordingly asserted (through a subcontractor) a lien on Nevils's settlement proceeds. *Id.* at 45a.

Nevils satisfied the lien but sued Coventry in Missouri state court, alleging that, notwithstanding

Coventry's OPM contract, Coventry's pursuit of subrogation or reimbursement violated Missouri's common-law antisubrogation doctrine. Pet. App. 45a. After Coventry unsuccessfully sought removal to federal court, the state trial court granted summary judgment for Coventry, holding that FEHBA preempts Nevils's claims. *Ibid.* Nevils appealed, and the court of appeals affirmed, agreeing with Coventry—and the United States, which participated as *amicus*—that FEHBA preempts Missouri's antisubrogation law. *Id.* at 36a-43a.

5. Nevils sought discretionary review in the Missouri Supreme Court to decide "[w]hether Missouri's anti-subrogation rule prohibiting an insurer from seeking reimbursement for benefits paid to its insured" is "preempted by 5 U.S.C. § 8902(m)(1)," which Nevils described as "an issue of great consequence to thousands of Missourians." Coventry Mo. S. Ct. Br. App. A.396 (Nov. 16, 2015) ("Coventry Remand Br."). The Missouri Supreme Court accepted the appeal and, in 2014, reversed in a divided decision (*Nevils I*). Pet. App. 46a-54a.

Disagreeing with Coventry, the United States, and multiple federal and state courts, *Nevils I* held that Section 8902(m)(1) does not preempt state antisubrogation and antireimbursement laws. Pet. App. 46a-54a. The court reasoned that the presumption against preemption and *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006)—which addressed federal-court *jurisdiction* over FEHBA reimbursement suits—require a narrow interpretation of Section 8902(m)(1). Pet. App. 47a-51a. The court also relied on *Kobold* v. *Aetna Life Insurance Co.* (*Kobold I*), 309 P.3d 924, 926-29 (Ariz. Ct. App. 2013), *review denied*, No. CV-13-299-PR (Ariz. Mar.

21, 2014), adopting *Kobold I*'s view that subrogation and reimbursement do not "relate to ... benefits" because they do not affect the amount of benefits participants are initially entitled to receive, but affect only participants' "net financial position after the provision of insurance benefits." Pet. App. 51a-53a.

Judge Wilson, joined by now-Chief Justice Breckenridge, concurred in the judgment. Pet. App. 55a-72a (Wilson, J., concurring in result). The concurring judges "disagree[d]" with the majority's statutory interpretation, concluding that Section 8902(m)(1) plainly evinces Congress's intent to preempt antisubrogation and antireimbursement laws. *Id.* at 55a-56a, 59a-66a. In their view, however, Section 8902(m)(1) violates the Constitution's Supremacy Clause, by purportedly giving preemptive effect to contractual provisions. *Id.* at 66a-72a.

6. Coventry sought certiorari, and this Court invited the United States' views. 135 S. Ct. 323 (2014). While Coventry's petition was pending, OPM proposed a regulation "reaffirm[ing]" OPM's longstanding position that FEHBA does preempt antisubrogation and antireimbursement laws because subrogation and reimbursement do "relate to the nature, provision and extent of coverage or benefits and benefit payments." *Proposed Rule*, 80 Fed. Reg. at 931-32. After receiving and reviewing comments, OPM promulgated a final rule in May 2015 codifying that position. *Final Rule*, 80 Fed. Reg. at 29,205 (codified at 5 C.F.R. § 890.106(h)).

The United States thereafter filed its invited brief, explaining that "[t]he decisio[n] of the Missouri Supreme Court" in *Nevils I* was "wrong, decide[d] an important and recurring question of federal law, ... open[ed] a conflict with decisions of other

state and federal courts on the same preemption question," and "should be reversed." U.S. Invitation Br. 11-12. The United States urged granting certiorari, vacating the Missouri Supreme Court's decision, and remanding in light of OPM's regulation. *Id.* at 20-21. OPM's interpretation of FEHBA, the government explained, is "entitled to the full measure of deference under *Chevron*," and the government perceived "a reasonable likelihood that the state cour[t] will conclude that OPM's regulations alter the outcome." *Id.* at 11-12, 22. The government urged the same course in *Kobold I*, in which the Court had also invited the government's views. *Ibid.*

Adopting the government's suggestion, this Court granted, vacated, and remanded in this case and *Kobold I* "for further consideration in light of [the] new regulations promulgated by [OPM]." 135 S. Ct. at 2886.

7. On remand, Coventry urged the Missouri Supreme Court to revisit its reading of FEHBA, but the court declined to do so. Instead, the principal opinion (for five of seven judges) addressed only whether OPM's regulation warranted a new result. Pet. App. 4a-13a. The court held that it did not, expressly refusing to accord any weight to OPM's interpretation. *Ibid.*

The court below asserted that *this* Court "has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause," and, "[a]bsent binding precedent requiring such deference," the Missouri Supreme Court would not defer. Pet. App. 5a, 8a-12a. Instead, it again applied a presumption against preemption. *Id.* at 6a-8a. And it expressly "decline[d] to follow" both the Arizona Court of Appeals' decision on remand—which re-

versed course and concluded that OPM's regulation is entitled to *Chevron* deference and "dispositive" on the preemption question, *Kobold* v. *Aetna Life Ins. Co.* (*Kobold II*), 370 P.3d 128, 130-32 (Ariz. Ct. App. 2016), *petition for review filed*, No. CV-16-0082-PR (Ariz. June 1, 2016)—and *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1109-10 (10th Cir. 2015), which held that OPM's interpretation is "persuasive" regardless of whether it is entitled to *Chevron* deference. Pet. App. 12a.

Judge Wilson again concurred only in the judgment—joined (as before) by Chief Justice Breckenridge, and now by four other members of the court who also joined the principal opinion. Pet. App. 14a (Wilson, J., joined by Breckenridge, C.J., and Fischer, Stith, Draper, and Russell, JJ., concurring in result); *id.* at 13a. Those six judges opined that, "for all the reasons stated in" Judge Wilson's "separate opinion" in *Nevils I*, Section 8902(m)(1) "is not a valid application of the Supremacy Clause," and therefore "does not displace Missouri law," because it purportedly "give[s] preemptive effect to the provisions of a contract between the federal government and a private party." *Id.* at 14a.

REASONS FOR GRANTING THE PETITION

The decision below solidifies an existing conflict regarding the interpretation of a federal statute that affects millions of federal workers, and creates a second split concerning the constitutionality of that statute. Both holdings contravene this Court's teaching and jeopardize the uniform, fair, and cost-efficient operation of a vital federal program.

The Missouri Supreme Court's holding that Congress intended to allow States to nullify subrogation

and reimbursement terms of FEHBA contracts cements the split extant when this Court vacated the Missouri court's prior ruling. The decision below directly conflicts with decisions of the Eighth Circuit—meaning state and federal courts in Missouri now disagree—as well as (*inter alia*) the Tenth Circuit, Georgia Supreme Court, and Arizona Court of Appeals. The Missouri court's reading of FEHBA is also irreconcilable with *this* Court's precedent. These conflicts concerning the construction of a federal statute amply justify plenary review.

The Missouri Supreme Court's additional determination—in a precedential concurrence joined by six of seven judges—that FEHBA's preemption provision is *unconstitutional* magnifies the need for this Court's intervention. That holding opens a new rift with every other court to consider the question, all of which have rejected the assertion that Section 8902(m)(1) violates the Supremacy Clause. It also badly misreads the statute. FEHBA itself supersedes certain state laws to make room for particular federal contracts to operate unimpeded; the statute simply refers to those contracts to delineate the scope of state law that *Congress* preempted. The Missouri Supreme Court's contrary view would leave Section 8902(m)(1) a dead letter—inviting States to nullify *any* provision of OPM's FEHBA contracts—and would place in grave peril multiple other federal statutes that define the scope of preemption in the same manner, including other federal-employee benefits statutes, ERISA, and the Federal Arbitration Act.

The stakes of both questions presented are staggering, as the United States' submissions in this Court and below make clear. The decision below

threatens to disrupt a multibillion-dollar federal program that serves millions of workers and dependents. And it would yield the very disuniformity, unfairness, and cost-inefficiency that Congress enacted Section 8902(m)(1) to avoid. This case provides the perfect opportunity to resolve these undeniably important questions and to restore clarity and uniformity to this highly significant area of federal law.

I. THE MISSOURI SUPREME COURT'S READING OF FEHBA'S PREEMPTION CLAUSE CEMENTS A LOWER-COURT SPLIT AND CONTRAVENES THE STATUTE AND THIS COURT'S PRECEDENT.

The Missouri Supreme Court's interpretation of Section 8902(m)(1)'s preemptive scope entrenches a conflict with multiple federal and state courts. And it cannot be reconciled with FEHBA's text and purpose or this Court's case law.

A. The Decision Below Conflicts With Multiple Federal And State Courts' Rulings Construing Section 8902(m)(1).

Every appellate court besides the Missouri Supreme Court to address the issue agrees that Section 8902(m)(1) preempts antisubrogation and antireimbursement laws—based either on the statute alone or deference to OPM's reading, now codified in its regulation. The Missouri Supreme Court has twice rejected that consensus view, and both its result and reasoning contradict other courts' decisions.

1. The Eighth Circuit has twice held that Section 8902(m)(1) preempts antisubrogation and antireimbursement laws. In *MedCenters Health Care* v. *Ochs*, 26 F.3d 865 (8th Cir. 1994), *abrogated on other grounds by McVeigh*, 547 U.S. 677—long before OPM's regulation—it held that Section 8902(m)(1)

preempted a state law that purported to prevent a FEHBA carrier from seeking subrogation under its OPM contract. *Id.* at 867.

The Eighth Circuit reaffirmed that holding earlier this year in *Bell* v. *Blue Cross & Blue Shield of Oklahoma*, __ F.3d __, 2016 WL 3027487 (8th Cir. May 26, 2016). Expressly "disagree[ing]" with the decision below, *Bell* held that, "[e]ven without deference to the agency under *Chevron*, the better reading of the statute's text" is that "reimbursement and subrogation provisions ... restrict the payment of benefits," and so "relate to 'benefits (including payments with respect to benefits)'" under Section 8902(m)(1). *Id.* at *4-5. *Bell* rejected the contention that the presumption against preemption compels a narrower reading of Section 8902(m)(1): Given the "obviously ... long history of federal involvement in federal employment and benefits," and the "'considerable,'" "'[d]istinctly federal interests'" in the operation of "a *federal* health insurance plan for *federal* employees that arise from a *federal* law," the court found "no warrant to place a thumb on the scales against preemptive effect of the federal statute." *Id.* at *3 (emphases added) (citations omitted).

Other courts read Section 8902(m)(1) the same way based on their own analysis of the statute. In *Thurman* v. *State Farm Mutual Automobile Insurance Co.*, 598 S.E.2d 448 (Ga. 2004), for instance, the Georgia Supreme Court held—in determining whether a FEHBA participant could seek uninsured-motorist benefits from her automobile insurer—that Section 8902(m)(1) preempted a state law that otherwise would have prevented the FEHBA carrier from seeking subrogation. *Id.* at 449-51; *see also Shields* v. *Gov't Emps. Hosp. Ass'n*, 450 F.3d 643, 648

(6th Cir. 2006), *overruled on other grounds by Adkins* v. *Wolever*, 554 F.3d 650, 652 (6th Cir. 2009) (en banc); *NALC Health Benefit Plan* v. *Lunsford*, 879 F. Supp. 760, 762-63 (E.D. Mich. 1995); *Aybar* v. *N.J. Transit Bus Operations, Inc.*, 701 A.2d 932, 937-38 (N.J. App. Div. 1997).

2. Still other courts have adopted the same reading of FEHBA by according varying degrees of deference to OPM's long-settled interpretation.

In *Kobold II*—on remand from this Court—the Arizona Court of Appeals held, notwithstanding its prior interpretation of Section 8902(m)(1), that OPM's regulation construing FEHBA to preempt antisubrogation and antireimbursement laws is "entitled to *Chevron* deference" and thus "dispositive." 370 P.3d at 130. OPM's interpretation is "procedurally eligible for *Chevron* deference," the court held, because it is codified in a notice-and-comment regulation that OPM was statutorily authorized to promulgate. *Ibid.* (citing 5 U.S.C. § 8913(a)). And OPM's view "qualif[ies] substantively for *Chevron* deference" because it is not "unreasonable." *Id.* at 131. *Chevron* therefore "compel[led]" the Arizona Court of Appeals "to apply OPM's interpretation." *Ibid.* The court's conclusion that deference applies to OPM's interpretations of Section 8902(m)(1)'s preemptive scope accords with *Blue Cross & Blue Shield of Florida, Inc.* v. *Department of Banking & Finance*, 791 F.2d 1501 (11th Cir.) (per curiam), *reh'g denied*, 797 F.2d 982 (11th Cir. 1986), which deferred to OPM's "reasonable" position that Section 8902(m)(1) preempts state laws regulating unclaimed federal-benefit checks. *Id.* at 1506.

The Tenth Circuit in *Helfrich* likewise relied on OPM's interpretation in determining that Section

8902(m)(1) preempts antisubrogation and antireimbursement laws. 804 F.3d at 1109-10. *Helfrich* found it unnecessary to resolve whether *Chevron* or a "less deferential standard" drawn from *Skidmore* v. *Swift & Co.*, 323 U.S. 134 (1944), applies, "because even under the less deferential standard" the Tenth Circuit "would adopt OPM's conclusion." 804 F.3d at 1109-10 & n.11. Like the Eighth Circuit in *Bell*, the Tenth Circuit emphatically rejected application of a presumption against preemption to Section 8902(m)(1): "The federalism concern ... behind the presumption ... has little purchase" given the powerful federal interests in a program that "governs only contracts for the benefit of federal employees" and the long "'history of significant federal presence' in the area." *Id.* at 1105 (citation omitted); *see also Calingo* v. *Meridian Res. Co.*, 2013 WL 1250448 (S.D.N.Y. Feb. 20, 2013) (according significant weight to OPM's reading, then expressed in a guidance letter).

3. The decision below directly conflicts with the reasoning and results of all of these decisions. In its divided 2014 decision in *Nevils I*, the Missouri Supreme Court expressly disagreed with *Thurman* and other cases and held that Section 8902(m)(1) does not preempt antisubrogation and antireimbursement laws. Pet. App. 46a-54a. The majority rejected OPM's and other courts' interpretation of Section 8902(m)(1)'s text, instead relying heavily on the presumption against preemption that the Eighth and Tenth Circuits have held inapplicable. *Ibid.*

Although this Court vacated *Nevils I* and remanded for further consideration in light of OPM's 2015 regulation, on remand the Missouri Supreme Court doubled down. Unlike the Arizona Court of

Appeals in *Kobold II*—which did change course in response to OPM's regulation—the Missouri court held once again that Section 8902(m)(1) does not preempt antisubrogation and antireimbursement laws. Pet. App. 4a-13a. Every step of its reasoning, moreover, conflicts with other courts' rulings. On remand the court declined to revisit its analysis of the statutory text, which the Eighth Circuit and Georgia Supreme Court among others have rejected. It relied again on the presumption against preemption that the Eighth and Tenth Circuits have held inapplicable. Pet. App. 6a-8a. And the court refused to accord any weight to OPM's view—"declin[ing] to follow" the Tenth Circuit's and Arizona Court of Appeals' contrary decisions, and making clear that it will not change its view "[a]bsent binding precedent requiring" such deference. *Id.* at 5a, 12a.

The decision below thus solidifies a direct conflict concerning the preemptive scope of a federal statute applicable to millions of federal workers and dependents nationwide. Indeed, because the Eighth Circuit has since explicitly disagreed with the Missouri Supreme Court's 2014 decision and its ruling on remand, *see Bell*, 2016 WL 3027487, at *5, FEHBA's preemptive scope in Missouri now turns on whether cases proceed in federal or state court. That conflict between federal and state courts in the same State presents a particularly urgent reason for review. *See, e.g.*, *Johnson* v. *California*, 545 U.S. 162, 164 (2005); *Hagen* v. *Utah*, 510 U.S. 399, 409 (1994). Given the Missouri Supreme Court's refusal to revisit its position on remand despite OPM's regulation—and that court's line-in-the-sand pronouncement that it will continue to disregard the agency's interpretation until specifically instructed otherwise by *this*

Court—there is no realistic prospect that the split will resolve itself.

B. The Missouri Supreme Court's Reading Of Section 8902(m)(1) And Refusal To Defer To OPM Contradicts FEHBA And This Court's Precedent.

The Missouri Supreme Court's outlier interpretation of Section 8902(m)(1) misreads the statute and departs fundamentally from this Court's teaching.

1. Construing any "pre-emption provision begins 'with the language of the statute itself,'" "'which necessarily contains the best evidence of Congress's preemptive intent.'" *Puerto Rico* v. *Franklin Cal. Tax-Free Trust*, 136 S. Ct. 1938, 1946 (2016) (citation omitted). Where "'the statute's language is plain,'" that "'is also where the inquiry should end.'" *Ibid.* (citation omitted). If the text alone is not conclusive, courts must examine Congress's "purpose"—the "ultimate touchstone of pre-emption analysis." *Wis. Dep't of Ind., Labor & Human Relations* v. *Gould Inc.*, 475 U.S. 282, 290 (1986) (internal quotation marks omitted). The decision below disobeyed these commands.

a. Section 8902(m)(1) expressly "supersede[s]" state laws that frustrate "[t]he terms of any [FEHBA] contract ... which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). As this Court has "repeatedly recognized," "relates to" in a preemption clause "express[es] a broad pre-emptive purpose" with an "'expansive sweep.'" *Morales* v. *Trans World Airlines, Inc.*, 504 U.S. 374, 383-84 (1992) (citation omitted); *accord Northwest, Inc.* v. *Ginsberg*, 134 S. Ct. 1422,

1428 (2014). Thus construed, Section 8902(m)(1) comfortably encompasses antisubrogation and antireimbursement laws.

i. "Subrogation and reimbursement clauses" relate to employees' *benefits* because, by definition, they make payment of benefits "conditional upon a right to subrogation or reimbursement of equivalent amounts, either from a third-party, or from the enrollee, in the event a third party is obligated to pay for the same injury or illness." *Proposed Rule*, 80 Fed. Reg. at 932. Indeed, this Court has specifically held in the context of *private* employee-benefit plans governed by ERISA that reimbursement "relate[s] to" benefits, and thus to private benefit plans, such that antireimbursement laws are preempted by ERISA's strikingly similar preemption clause, 29 U.S.C. § 1144(a). *FMC*, 498 U.S. at 58-60.

The Missouri Supreme Court has twice held that subrogation and reimbursement do *not* "relate to ... benefits," Pet. App. 1a-2a, 4a-13a, 51a-54a, but it has never attempted to square that view with this Court's decisions construing "relate to" expansively or *FMC*'s interpretation of ERISA's parallel provision—all of which Coventry presented. Coventry Remand Br. 33-36. Nor is there any basis to construe FEHBA's "nearly identical ... preemption provision" more narrowly than ERISA. *Pharm. Care Mgmt. Ass'n* v. *Rowe*, 429 F.3d 294, 299-300 n.2 (1st Cir. 2005). Lower courts have repeatedly looked to ERISA case law in interpreting Section 8902(m)(1). *See, e.g., ibid.*; *Botsford* v. *Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002); *Aybar*, 701 A.2d at 935-36. And, as the government has explained, "[i]t is exceedingly unlikely that Congress intended a *broader* role for state law in the

case of federal employees than in the case of private employees, or that Congress desired *less* uniformity in the case of federal employees." Pet. App. 178a (emphases added).

The Missouri Supreme Court's only textual analysis further disregards this Court's teaching. The court's 2014 opinion in *Nevils I*—to which it adhered on remand, Pet App. 1a-2a—reasoned that subrogation and reimbursement do not "relate to ... benefits" because they do not affect the amount of benefits a participant is initially entitled to receive, but govern only what the participant must repay later. Pet. 52a-53a. That facile distinction is illusory: Regardless of the amount of benefits a FEHBA participant *initially* receives, subrogation and reimbursement rights directly affect how much the participant may *retain*.

This Court has emphatically rejected a similar, equally artificial distinction in the setting of federal employees' life insurance. In *Hillman* v. *Maretta*, 133 S. Ct. 1943 (2013), it held that a federal law prescribing who receives life-insurance payments impliedly preempted a state law directing recipients of life-insurance payments to *transfer* them to someone else. *Id.* at 1952. It "makes no difference," *Hillman* explained, whether a state law withholds benefits in the first instance or takes them away after they have been paid; "[i]n either case, state law displaces the beneficiary selected" by federal law, and so is preempted. *Ibid.* The Missouri Supreme Court's claim that reimbursement is irrelevant to benefits because it affects only whether the recipient may *keep* what she initially receives rings hollow.

The decision below also relied on dictum in *McVeigh* describing competing interpretations of

Section 8902(m)(1) as "plausible." 547 U.S. at 697-98; Pet. App. 3a, 49a. But *McVeigh*, which addressed only federal-court *jurisdiction* over FEHBA carriers' reimbursement actions, expressly reserved judgment on Section 8902(m)(1)'s scope because it made no difference there. 547 U.S. at 698 ("we need not choose between" proffered constructions). Even read for all it might be worth, *McVeigh*'s dictum hardly justifies declaring Section 8902(m)(1)'s words a wash, as the court below did. "[T]o acknowledge ambiguity is not to conclude that all interpretations are *equally* plausible." *Gwaltney of Smithfield, Ltd.* v. *Chesapeake Bay Found., Inc.*, 484 U.S. 49, 57 (1987) (emphasis added).

ii. The Missouri Supreme Court not only distorted the text it addressed, but it ignored another critical part of the text altogether. Regardless of whether subrogation and reimbursement relate to *benefits*, they certainly "relate to" the "*provision*" of "*payments with respect to* benefits," 5 U.S.C. § 8902(m)(1) (emphases added); *see Helfrich*, 804 F.3d at 1106. The whole point of subrogation and reimbursement is to *undo* or *reduce* prior benefit payments. Reimbursement requires the insured herself to return to the carrier the value of benefits previously provided. And subrogation requires the insured to surrender to the carrier her right to recover from the third party. 5 C.F.R. § 890.101(a).

Both in its original decision and on remand, the court below was presented with this independently dispositive text. Pet. App. 176a-77a; Coventry Remand Br. 38-40. Yet neither decision addressed it.

b. The Missouri Supreme Court's interpretation of Section 8902(m)(1) also thwarts Congress's purpose—which the court below never confronted. Con-

gress enacted Section 8902(m)(1) to address concerns that state laws mandating the benefits FEHBA plans offer would cripple uniformity and make administration of nationwide plans unmanageable. S. Rep. No. 95-903, at 7-8 (1978); H.R. Rep. No. 95-282, at 3-7 (1977); H.R. Rep. No. 94-1211, at 3. Congress later *broadened* Section 8902(m)(1) "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9.

Construing Section 8902(m)(1) to supersede anti-subrogation and antireimbursement laws "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." *Final Rule*, 80 Fed. Reg. at 29,203. It also advances the "strong federal interest in national uniformity in coverage and benefits," which "include[s] uniform administration of the FEHB program across state lines." *Proposed Rule*, 80 Fed. Reg. at 932.

In contrast, allowing state laws to block carriers from seeking subrogation and reimbursement defeats Congress's objectives. As the government has explained, "Missouri's anti-subrogation rule is indistinguishable from the state mandated-benefit laws that Congress expressly targeted with the enactment of the FEHBA preemption provision," as it "requires FEHB providers to provide Missouri consumers with FEHB benefits that consumers in other states do not receive under the terms of the same FEHB contract." Pet. App. 179a. "If Missouri's anti-subrogation rule survives preemption, the loser will be FEHB enrollees in states that permit subrogation, who will be

subsidizing the more generous benefits that Missouri law effectively mandates that FEHB carriers provide to Missouri residents"—"creat[ing] precisely the disuniformity that Congress intended to preclude," and undermining Congress's goal of facilitating carriers' cost-cutting efforts. *Ibid.*

Indeed, as the United States and Coventry showed below, antisubrogation and antireimbursement laws pose such an "'obstacle to the accomplishment and execution of the full purposes and objectives of Congress'" that they would be impliedly preempted even if Section 8902(m)(1) did *not* apply. Pet. App. 180a (quoting *Arizona* v. *United States*, 132 S. Ct. 2492, 2505 (2012)); Coventry Remand Br. 43-45; *see also Hillman*, 133 S. Ct. at 1949-55 (holding state law impliedly preempted by federal-employee life-insurance statute without addressing express preemption). Congress's purposes in enacting that express-preemption provision confirm that it encompasses such laws.

2. The Missouri Supreme Court compounded its error by refusing to defer to OPM's reasonable interpretation. Under *Chevron*, an agency's reading of a statute it administers, expressed in a notice-and-comment regulation, "governs if it is a reasonable interpretation of the statute"—regardless of whether it is "the only possible interpretation" or "even the interpretation deemed *most* reasonable by the courts." *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 (2009). This rule applies to "*all* the matters the agency is charged with administering." *City of Arlington* v. *FCC*, 133 S. Ct. 1863, 1874 (2013).

Chevron required the court below to defer to OPM's regulation interpreting FEHBA to preempt antisubrogation and antireimbursement laws. Con-

gress expressly authorized OPM to issue regulations administering FEHBA. 5 U.S.C. § 8913(a). Even if other readings of Section 8902(m)(1) were also permissible, OPM's reading is at least reasonable. The decision below itself conceded that OPM's reading is "plausible." Pet. App. 3a.

The Missouri Supreme Court nevertheless refused to accord OPM's view any weight. It asserted that *Chevron* is categorically inapplicable to express-preemption provisions, and that this "Court has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause." Pet. App. 5a, 8a-12a. That is wrong.

This Court has flatly rejected the assertion that *Chevron* applies piecemeal to some topics under a statute an agency administers but not others. *City of Arlington*, 133 S. Ct. at 1874. Where an agency is authorized to interpret a statute, "the whole includes all of its parts"; *Chevron* applies to them all. *Ibid.* That principle applies with full force to an agency's interpretation of the "meaning" of a provision that "pre-empts state law." *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735, 744 (1996).

Indeed, this Court has held that, even independent of an express-preemption provision, regulations issued by an agency acting within its rulemaking authority "'have no less pre-emptive effect than federal statutes,'" for "'[w]here Congress has directed an administrator to exercise his discretion, his judgments are subject to judicial review only to determine whether he has exceeded his statutory authority or acted arbitrarily.'" *Capital Cities Cable, Inc.* v. *Crisp*, 467 U.S. 691, 699 (1984) (citation omitted). Thus, even without "'express congressional authorization to displace state law,'" "if the agency's choice

to pre-empt 'represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute, [courts] should not disturb it unless it appears from the statute or its legislative history that the accommodation is not one that Congress would have sanctioned.'" *City of New York* v. *FCC*, 486 U.S. 57, 64 (1988) (citation omitted). *A fortiori*, where Congress *has* expressly preempted some state laws, the agency's reasonable interpretation of the scope of that preemption deserves deference.

Applying this principle, this Court has repeatedly deferred to agency interpretations of statutes that preempt state law. *Smiley*, for example, expressly held that *Chevron* required deferring to the Comptroller of the Currency's reasonable view of the scope of a statute (12 U.S.C. § 85) that this Court had already determined "pre-empts state law." 517 U.S. at 743-45. The Missouri Supreme Court perplexingly read *Smiley* to *preclude* deference, Pet. App. 9a-10a; that reading is backwards. *Smiley* distinguished "the question of the substantive (as opposed to pre-emptive) *meaning* of a statute with the question of *whether* a statute is pre-emptive" at all. 517 U.S. at 744. *Smiley* "assume[d] (without deciding) that the latter question"—whether a statute preempts *anything*—is not subject to *Chevron*. *Ibid.* But *Smiley* held that, where "there is no doubt" that the statute preempts *some* state laws, *Chevron* applies with full force to the agency's reasonable interpretation of *which* state laws. *Ibid.*

The decision below also ignored or distorted this Court's later decisions confirming this principle. In *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 496-97 (1996)—the relevant holding of which the decision

below never addressed—this Court deferred to a Food and Drug Administration regulation construing the scope of an express-preemption provision regarding medical devices, 21 U.S.C. § 360k(a). And *Cuomo* v. *Clearing House Ass'n, LLC*, 557 U.S. 519 (2009), held that "the familiar *Chevron* framework" applied to an express-preemption provision, and declined to defer only because the "outer limits" of the statute were "clear" and the agency's reading strayed beyond those "bounds." *Id.* at 525. The Missouri Supreme Court misread *Clearing House* as deeming *Chevron* irrelevant, Pet. App. 11a-12a—an error this Court's opinion refutes.

The Missouri Supreme Court thus had no warrant to "declin[e]" to defer (Pet. App. 5a) to OPM's regulation. At a minimum, it was obliged to give respectful consideration to the "longstanding and persuasively explained" view of OPM—which, "[a]s the agency that has negotiated FEHBA contracts for federal employees for years, ... has deep knowledge of the impact and interrelationships of contractual provisions." *Helfrich*, 804 F.3d at 1109-10; *see Kasten* v. *Saint-Gobain Performance Plastics Corp.*, 131 S. Ct. 1325, 1335-36 (2011). The Missouri Supreme Court's refusal to accord OPM's reading any weight flouts this Court's case law.

3. The interpretive principle the decision below substituted for *Chevron* further contradicts this Court's precedent. Instead of "presum[ing]" that Congress desired any "ambiguity" to "be resolved, first and foremost, by the agency," *Smiley*, 517 U.S. at 740-41, the decision below applied a presumption against preemption. Pet. App. 6a-8a. But this Court's case law makes clear that the presumption is inapplicable to Section 8902(m)(1), and in any event

cannot overcome Congress's clearly evinced intent or OPM's reasonable position.

The presumption against preemption is irrelevant at the outset because Section 8902(m)(1) *expressly* preempts state law. Where a "statute contains an express pre-emption clause," this Court has held, courts should "*not* invoke any presumption against pre-emption," but should "instead focus on the plain wording of the clause." *Franklin*, 136 S. Ct. at 1946 (emphasis added) (internal quotation marks omitted).

Moreover, the presumption "is not triggered" in areas "where there has been a history of significant federal presence," *United States* v. *Locke*, 529 U.S. 89, 108 (2000), or where the "interests at stake are 'uniquely federal' in nature," *Buckman Co.* v. *Plaintiffs' Legal Comm.*, 531 U.S. 341, 347 (2001) (citation omitted); *see also Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016). *Both* are true of the provision of benefits to federal employees. *See Bell*, 2016 WL 3027487, at *2-4; *Helfrich*, 804 F.3d at 1104-06. Contracts "concer[ning] benefits from a *federal* health insurance plan for *federal* employees that arise from a *federal* law" implicate "'[d]istinc[t] *federal* interests.'" *Bell*, 2016 WL 3027487, at *3, *5 (emphases added) (citation omitted). Even the court below acknowledged the "strong federal interest" at stake. Pet. App. 12a. And it is "an understatement to say that 'there has been a history of significant *federal* presence' in the area of *federal* employment." *Helfrich*, 804 F.3d at 1105 (emphases added) (citation omitted). There is thus no reason to assume that, in enacting (and expanding) FEHBA's preemption provision, Congress intended to tread lightly.

In any event, the presumption against preemption could not overcome FEHBA's clear text and purpose, or OPM's position. Even "state laws 'governing'" issues of paradigmatic state concern—such as "family law"—"'must give way to clearly conflicting federal enactments.'" *Hillman*, 133 S. Ct. at 1950 (citation omitted). And even if Section 8902(m)(1)'s text were ambiguous, this Court has made clear that the presumption against preemption does not "trum[p] *Chevron*." *Smiley*, 517 U.S. at 743-44. Because OPM's reading merits *Chevron* deference, the presumption never comes into play. *See ibid.*; *New York* v. *FERC*, 535 U.S. 1, 18 (2002).

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The decision below yields an intractable lower-court conflict. And its interpretation of FEHBA's preemption provision flouts Congress's direction and this Court's teaching at every turn. Only this Court can definitively resolve the split and conclusively resolve Section 8902(m)(1)'s proper scope.

II. THE MISSOURI SUPREME COURT'S HOLDING THAT FEHBA'S PREEMPTION CLAUSE IS UNCONSTITUTIONAL CREATES A FURTHER LOWER-COURT CONFLICT AND IS INCORRECT.

The decision below opened a second lower-court rift and exacerbated its errors by further concluding—in a six-judge concurrence that now governs in Missouri—that Section 8902(m)(1) is unconstitutional. That additional holding striking down an exceptionally important federal statute and the conflict it creates urgently warrant this Court's intervention.

A. The Decision Below Creates A Second, Direct Conflict Concerning Section 8902(m)(1)'s Constitutionality.

1. Until the decision below, federal and state courts consistently held that Section 8902(m)(1) comports with the Supremacy Clause. In *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 396 F.3d 136 (2d Cir. 2005) (Sotomayor, J.), *aff'd*, 547 U.S. 677, the Second Circuit directly addressed the concern that, if Section 8902(m)(1) were construed to give preemptive effect to something *other* than federal laws, it would violate the Supremacy Clause. *Id.* at 143-44. As the Second Circuit explained, that concern is easily resolved by "reasonably construing" Section 8902(m)(1) "as requiring that, in cases involving the 'terms of any contract under FEHBA which relate to the nature, provision, or extent of coverage or benefits,' *federal law* 'shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.'" *Id.* at 144 (citation and brackets omitted). Even the dissent agreed on this point. *Id.* at 156 (Raggi, J., dissenting).

Other courts since have agreed. In *Bell*, after noting that the plaintiff failed to challenge Section 8902(m)(1)'s constitutionality below, the Eighth Circuit rejected that challenge. 2016 WL 3027487, at *5 (finding "no obvious error that warrants correction on appeal"). Expressly disagreeing with the six-judge concurrence in this case, *Bell* adopted the Second Circuit's view that "the statute can reasonably be construed to mean that federal law ... , not the contractual terms, has the preemptive force," obviating any Supremacy Clause concern. *Ibid.* Likewise, in *Kobold II*, the Arizona Court of Appeals held that

Section 8902(m)(1) does not violate the Supremacy Clause. 370 P.3d at 131 n.2. "FEHBA contract terms," it explained, are "circumscribed by the terms of the FEHBA and the standards prescribed by the OPM," which by regulation *requires* FEHBA contracts to include subrogation and reimbursement clauses. *Ibid.*

2. A supermajority of the Missouri Supreme Court here, however, struck down Section 8902(m)(1) as a violation of the Supremacy Clause. In *Nevils I*, Judge Wilson (joined by now-Chief Justice Breckenridge), while rejecting the majority's statutory interpretation, opined that Section 8902(m)(1) was inoperative because it violates the Supremacy Clause—expressly disagreeing with "the saving construction offered by then-Judge Sotomayor" in *McVeigh*. Pet. App. 70a. On remand, Judge Wilson—joined again by Chief Justice Breckenridge *and* by four additional judges, *id.* at 13a—adhered to that view. *Id.* at 14a. Those six judges opined that, "for all of the reasons stated in" Judge Wilson's prior "separate opinion," Section 8902(m)(1)'s "attempt to give preemptive effect to the provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause." *Ibid.*

That constitutional determination by a majority of the Missouri Supreme Court—by more judges than joined the lead opinion—is now controlling in Missouri state courts. Under Missouri law, a "concurring opinion" in which "a majority of the court concur[s]" is binding precedent. *Mueller* v. *Burchfield*, 224 S.W.2d 87, 89 (Mo. 1949) (holding that concurrence "overruled" prior precedent). That is true even where, as here, the concurrence's rationale is broader than that of the principal opinion. *See State*

ex rel. Bothwell v. *Green*, 180 S.W.2d 12, 13 (Mo. 1944) (holding that prior concurring opinion had "overruled" earlier precedent, even though principal opinion had "attempted to distinguish" that precedent). Missouri courts now are bound to conclude in future cases that Section 8902(m)(1) has *no* preemptive effect, even as to issues that indisputably "relate" to coverage or benefits, because under the decision below that federal statutory provision is entirely invalid.

B. The Missouri Supreme Court's Holding That Section 8902(m)(1) Violates The Supremacy Clause Is Wrong.

The concurrence's precedential determination that Section 8902(m)(1) is unconstitutional is incorrect and rests on a fundamental misunderstanding of the statute. FEHBA does not, as the concurring judges asserted, make contract terms themselves preempt state law. As the Second Circuit and other courts have explained, it is Section 8902(m)(1) *itself* that declares the state laws it covers "'supersede[d] and preempt[ed].'" *McVeigh*, 396 F.3d at 144-45 (quoting 5 U.S.C. § 8902(m)(1)). FEHBA simply defines the scope of preemption by reference to a class of federal contracts. What matters is that *Congress*, by enacting a statute—one of "the Laws of the United States," U.S. Const. art. VI, cl. 2—prescribed the existence and scope of preemption; that is all the Supremacy Clause requires. Even if Section 8902(m)(1) could be read differently, it certainly *can* (and therefore must) be read in this sensible fashion, which averts any constitutional concern. *See Edward J. DeBartolo Corp.* v. *Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988).

This aspect of FEHBA's preemption provision, in fact, is unremarkable. Congress can and does define the scope of preemption in a variety of ways—sometimes preempting all laws on a topic, *see, e.g.*, *Morales*, 504 U.S. at 383 (addressing 49 U.S.C. App. § 1305(a)(1)); sometimes preempting only state laws that contradict or add to particular federal requirements, *see, e.g.*, *Riegel* v. *Medtronic, Inc.*, 552 U.S. 312, 316 (2008) (applying 21 U.S.C. § 360k(a)); and sometimes preempting an area of state law defined by reference to particular contracts—as it did in FEHBA, 5 U.S.C. § 8902(m)(1), as well as other federal benefits statutes, *id.* §§ 8709(d)(1), 8959, 8989, 9005(a); 10 U.S.C. § 1103(a), the Federal Arbitration Act, 9 U.S.C. § 2, and ERISA, 29 U.S.C. § 1144(a).

If Congress (as no one disputes) can enact the first two types of preemption clauses, there is no reason, and the decision below offered none, why it cannot enact the third. Such laws, including FEHBA, pass constitutional muster because *Congress* defined the scope of preemption in a duly enacted law. The decision below, however, would call the validity of all federal statutes that link the scope of preemption to contracts or other instruments into grave doubt.

III. This Case Is An Excellent Vehicle To Resolve The Important And Recurring Questions Of The Scope And Validity Of FEHBA's Preemption Clause.

The statutory and constitutional questions this case presents are indisputably important. This case provides an ideal opportunity to answer them.

A. As the United States and Nevils each have noted, "whether States can prohibit subrogation under a FEHB contract" is "important." U.S. Invitation

Br. 17; *accord* Coventry Remand Br. App. A.396 (Nevils arguing that question presented is "an issue of great consequence"). The FEHBA Program provides tens of billions of dollars in benefits to millions of federal workers and dependents each year. *Final Rule*, 80 Fed. Reg. at 29,203. "Subrogation recoveries translate to premium cost savings" for those participants and for taxpayers. *Ibid.* By allowing States to forbid such recoveries, the decision below will greatly increase the Program's costs. And it puts FEHBA carriers—which are contractually *required* to seek subrogation and reimbursement, U.S. Invitation Br. 4—to an untenable choice between fulfilling their duties to OPM and obeying state law.

The decision below compounds these problems by permitting each State to apply its own requirements. "Most FEHB enrollees receive benefits under nationwide plans[.]" Pet. App. 179a. Without preemption, carriers thus must navigate an "'administratively burdensome'" labyrinth of diverse state-law rules that "'gives rise to uncertainty and litigation.'" U.S. Invitation Br. 15 (citation omitted); *see* Ass'n of Fed. Health Orgs., *State Laws Restricting Subrogation and Reimbursement* (2014), http://tinyurl.com/podatzj (summarizing patchwork of state subrogation laws). This disuniformity will also "resul[t] in unfairness and real-world financial harm to federal employees" by "creat[ing] a cross-subsidy problem": The decision below "effectively ... force[s]" FEHBA "[p]articipants who live in States that allow subrogation ... to cross-subsidize participants in the same plan who live in States that prohibit it." U.S. Invitation Br. 17.

The need for this Court's intervention is even greater now than when this case was last before the

Court. It was "precisely ... the importance of this question as a matter of federal policy" that prompted OPM to promulgate its regulation, which the government hoped would resolve the conflict. U.S. Invitation Br. 20-21. That effort, however, has failed. This Court gave the state courts in this case and *Kobold* an opportunity to modify their conclusions in light of the regulation, but the Missouri Supreme Court (unlike the Arizona court in *Kobold*) refused. It has made clear, moreover, that no further action by OPM will make any difference, based on the court's mistaken view that OPM's interpretation of FEHBA's preemptive scope deserves no deference. Plenary review by this Court is now the only option.

The Missouri Supreme Court's further holding striking down Section 8902(m)(1) as unconstitutional makes plenary review more urgent still. By holding that Section 8902(m)(1) preempts *nothing*, the decision below permits States to nullify *any* FEHBA-contract provision—even those that unquestionably "relate to" the "provision" of "coverage" or "benefits." Unless overturned, that ruling will make administration of FEHBA plans utterly impracticable in Missouri—and any State or Circuit that follows suit.

B. This Court can and should avert these grave harms by definitively resolving these statutory and constitutional questions. This case provides the perfect opportunity.

Both the statutory-interpretation and constitutional questions were thoroughly pressed and passed upon below. As the United States explained previously, the Missouri Supreme Court's 2014 decision "squarely present[ed] the preemption question." U.S. Invitation Br. 18. This Court remanded for the state court to reconsider that question with the benefit of

OPM's regulation, which the court below has now done, refusing to alter its position. Pet. App. 1a-2a. The question of Section 8902(m)(1)'s constitutionality was also thoroughly litigated in the Missouri Supreme Court, which in a precedential concurrence squarely addressed it. *Id.* at 14a (Wilson, J., concurring in result). The concurrence leaves no doubt that, if this Court were to reverse only the state court's statutory interpretation, the Missouri Supreme Court will continue to deem Section 8902(m)(1) a nullity.

The applicability and validity of FEHBA's preemption provision is also outcome-determinative. The state trial court granted, and the court of appeals affirmed, summary judgment for Coventry based on their conclusion that FEHBA forecloses Nevils's state-law claim. If this Court reverses the decision below and holds that FEHBA's preemption provision is applicable and constitutional, Coventry will be entitled to judgment, and the case will end.

For the same reason, the decision below is "final" under 28 U.S.C. § 1257(a). "[T]he federal issue[s] ha[ve] been finally decided," "reversal of the state court on the federal issue would be preclusive of any further litigation," and "a refusal immediately to review the state court decision might seriously erode federal policy." *Cox Broad.*, 420 U.S. at 482-83; Pet. for Cert. 35-36, No. 13-1305 (U.S. Apr. 28, 2014); U.S. Invitation Br. 19-20. "Forcing a FEHB carrier to defend against a putative state-law class action seeking damages because the carrier performed its contractual commitments to OPM and exercised its subrogation rights would plainly undermine OPM's policy that carriers should exercise their subrogation

rights unimpeded by such parochial state laws." U.S. Invitation Br. 20.

Nevils's makeweight assertion in unsuccessfully opposing Coventry's prior petition that Coventry's contract did not authorize it to seek reimbursement is meritless. As the Missouri Supreme Court expressly held in *Nevils I*, Coventry's contract "direct[ed] [it] to seek reimbursement or subrogation" in these circumstances. Pet. App. 45a. That "interpretation of the contract," the government and Coventry showed, "is correct." U.S. Invitation Br. 18; Cert. Reply 12, No. 13-1305 (U.S. July 16, 2014). Nevils himself, in fact, repeatedly told the state courts the same thing, agreeing that Coventry's contract authorized reimbursement and urging the state courts to decide the federal issues on that basis. *See* Coventry Remand Br. 89-92. And although on remand Nevils changed his tune, urging the court below not to reach the preemption issues, the Missouri Supreme Court was unmoved and pressed forward to decide both the statutory and constitutional questions.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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August 1, 2016

APPENDIX

APPENDIX A

SUPREME COURT OF MISSOURI
en banc

JODIE NEVILS,	)	
	)	
APPELLANT,	)	
	)	
vs.	)	**No. SC93134**
	)	
GROUP HEALTH PLAN, INC., and ACS RECOVERY SERVICES, INC.,	)	
	)	
RESPONDENTS.	)	

APPEAL FROM THE CIRCUIT COURT OF ST. LOUIS COUNTY
Honorable Thea A. Sherry, Judge

Opinion issued May 3, 2016

In *Nevils v. Group Health Plan, Inc.*, 418 S.W.3d 451, 457 (Mo. banc 2014), this Court held that 5 U.S.C. section 8902(m)(1) of the Federal Employee Health Benefits Act (FEHBA) did not preempt Missouri law prohibiting subrogation of personal injury claims. The United States Supreme Court granted certiorari, vacated this Court's decision in *Nevils*, and remanded the case for this Court to determine whether a new regulation promulgated by the Office of Personnel Management (OPM) establishes that FEHBA preempts Missouri's anti-subrogation law. *Group Health Plan Inc., v. Nevils,* 135 S. Ct. 2886 (2015).

The United States Supreme Court has never held that a regulation promulgated by an executive branch administrative agency determines the scope of Congress' exercise of its legislative prerogative to expressly preempt state law. Instead, the Court has held consistently that courts should presume that there is no preemption and that a federal statute preempts state law only if it demonstrates Congress' clear and manifest intent to preempt state law. The text of the FEHBA preemption clause has not changed, and the OPM regulation does not overcome the presumption against preemption and demonstrate Congress' clear and manifest intent to preempt state law. Therefore, this Court holds that the OPM regulation does not establish that FEHBA preempts Missouri law prohibiting the subrogation of personal injury claims.

Background

Jodie Nevils (Appellant) was a federal employee with a health insurance plan governed by FEHBA. FEHBA expressly preempts state law as follows:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. section 8902(m)(1).

Appellant filed suit against Group Health Plan, Inc.,[1] and ACS Recovery Services, Inc., after Coven-

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[1] Group Health Plan, Inc., is now Coventry Health Care of Missouri, Inc., and will hereafter be referred to as "Coventry."

try and ACS enforced a subrogation lien against the proceeds from Appellant's settlement of a personal injury claim. Appellant alleged that the subrogation lien violated Missouri law prohibiting the subrogation of personal injury claims. The trial court entered summary judgment in favor of Coventry and ACS on grounds that FEHBA preempts Missouri anti-subrogation law.

This Court reversed the summary judgment and held that the FEHBA preemption clause did not preempt Missouri anti-subrogation law because the subrogation of a personal injury claim does not clearly "relate to the nature, provision, or extent of coverage or benefits." *Nevils*, 418 S.W.3d at 455. This Court's analysis began with the principle that the "historic police powers of the States" are generally preempted only when the federal statute at issue indicates that preemption is the "clear and manifest purpose of Congress." *Id.* at 454 (quoting *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504 (1992)). "[W]hen two plausible readings of a statute are possible, 'we would nevertheless have a duty to accept the reading that dis-favors preemption.'" *Id.* (quoting *Bates v. Dow Agrosciences, L.L.C.*, 544 U.S. 431, 449 (2005)). The FEHBA preemption clause is ambiguous because it is subject to plausible, alternate interpretations. *Id.* at 454 (citing *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 697 (2006)). Specifically, the FEHBA preemption clause does not address the subrogation or reimbursement rights of insurance providers, *id.* at 455 (citing *Empire*, 547 U.S. at 683), and "there is no indication that Congress delegated to the OPM the authority to make binding interpretations of the scope of the FEHBA preemption clause," *id.* at 457 n.2. In addition to the presumption against preemption, this

Court noted that a "cautious" reading of the FEHBA preemption clause was further warranted because the statute takes the unusual step of providing that the terms of a privately negotiated contract preempt state law. *Id.* at 455. Consequently, this Court held that the plain language of the FEHBA preemption clause does not establish a clear and manifest congressional intent to preempt state anti-subrogation law. *Id.* at 457.

Following this Court's opinion in *Nevils*, the OPM promulgated a formal rule providing that:

> A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 C.F.R. § 890.106(h). The United States Supreme Court granted certiorari, vacated this Court's decision in *Nevils*, and remanded the case to this Court to determine whether the foregoing rule establishes that FEHBA preempts Missouri's anti-subrogation law.

Analysis

Coventry argues that the OPM's new rule providing that FEHBA preempts state anti-subrogation law is dispositive and requires this Court to hold that FEBHA preempts Missouri's anti-subrogation law. Coventry asserts that the OPM rule is entitled to

deference pursuant to *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). *Chevron* held that when resolving statutory ambiguities, courts should defer to an executive administrative agency's interpretation of the statute through formally promulgated administrative rules. *Id.* 842-43.[2] "*Chevron* deference" is typically applied "[w]here an agency rule sets forth important rights and duties, where the agency focuses fully and directly on the issue, where the agency uses notice-and-comment procedures to promulgate a rule, [and] where the resulting rule falls within the statutory grant of authority." *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 173 (2007).

The OPM rule at issue was promulgated formally pursuant to notice and comment rulemaking. The text of the FEHBA preemption clause, however, remains unchanged. To reverse course from the holding in *Nevils*, this Court would have to hold that the OPM's rule is dispositive as to Congress' intent to preempt state law. While *Chevron* has been applied repeatedly to determine the substantive meaning of a statute, the United States Supreme Court has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause. Absent binding precedent requiring such deference, this Court declines to afford dispositive deference to an executive agency's interpretation of a statutory preemption clause.

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[2] The statutory term at issue in *Chevron* was a provision of the Federal Clean Air Act establishing permitting requirements for "new or modified major stationary sources." 467 U.S. at 840. Therefore, the Court's holding that the agency rule regarding what constituted a "source" of air pollution was entitled to deference related only to the substantive meaning of the statute rather than its preemption of conflicting state law.

The Supremacy Clause of the United States Constitution provides that state laws and constitutional provisions are preempted when in conflict with federal laws. *See Johnson v. State*, 366 S.W.3d 11, 26-27 (Mo. banc 2012). "In determining whether a state statute is pre-empted by federal law and therefore invalid under the Supremacy Clause of the Constitution, our sole task is to ascertain the intent of Congress." *California Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 280 (1987). "Accordingly, 'the purpose of Congress is the ultimate touchstone of pre-emption analysis.'" *Cipollone*, 505 U.S. 504 at 516 (1992) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)); *see also Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (Congress' purpose is the "ultimate touchstone" for determining the existence and reach of preemption).

While Congress' intent and purpose are the determinative factors, preemption analysis "starts with the basic assumption that Congress did not intend to displace state law." *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981); *see also Cipollone*, 505 U.S. at 516 (preemption analysis "starts with the assumption that the historic police powers of the States [are] not to be superseded by" federal statute). There are two aspects to the presumption against preemption. *City of Belton v. Smoky Hill Ry. & Historical Soc., Inc.*, 170 S.W.3d 429, 434 (Mo. App. 2005) (quoting *Medtronic, Inc.*, 518 U.S. 470 at 485 (1996)). First, it is presumed that the states' historic police powers are not preempted unless it is the clear intent of Congress to preempt state law. *Id.* Second, a court's analysis of the scope of a statute's preemption is determined by the congressional purpose in enacting the statute. *Id.* When two plausible readings of a statute are possible, "we would nevertheless have a

duty to accept the reading that disfavors preemption." *Bates*, 544 U.S. 431 at 449 (2005).

As this Court noted in *Nevils*, the United States Supreme Court has recognized that the FEHBA preemption clause is subject to plausible, alternate interpretations. 418 S.W.3d at 454-455 (citing *Empire Healthchoice Assurance Inc.*, 547 U.S. 677 at 697 (2006)). The Court also noted that the "choice-of-law prescription is unusual in that it renders superior preemptive contract terms in health insurance plans, not provisions enacted by Congress [ ] and that such an unusual order warrants [a] cautious interpretation." *Id.* The fact that the FEHBA preemption clause is susceptible to alternate interpretations implicates the presumption against preemption and counsels that preemption is warranted only if Congress expressed its clear and manifest intent that the purposes of FEHBA require the preemption of state anti-subrogation laws. Coventry's argument that this Court must give dispositive deference to the new OPM rule is a tacit admission that Congress did not express its clear and manifest intent that the purpose of FEHBA requires preemption of state anti-subrogation law.

Cipollone illustrates the Supreme Court's application of the presumption against preemption when an express preemption clause is at issue. In *Cipollone*, the issue was whether the Federal Cigarette Labeling and Advertising Act preempted state law claims based on failure to warn, breach of express warranty, fraudulent misrepresentation, and conspiracy. The act contained an express preemption clause that "governed entirely" the preemptive scope of the Act. 505 U.S. at 517. The preemption clause provided that "[n]o *statement* relating to smoking

and health shall be required *in the advertising* of properly labeled cigarettes." *Id.* The Supreme Court applied the presumption against preemption to analyze separately whether each of the asserted state law claims was preempted. The Supreme Court stated that "we must construe these provisions in light of the presumption against the pre-emption of state police power regulations. This presumption reinforces the appropriateness of a narrow reading ...." *Id.* at 518. The Supreme Court also emphasized that courts "must fairly but – in light of the strong presumption against pre-emption – narrowly construe the precise language of [the preemption clause] and we must look to each of petitioner's common-law claims to determine whether it is in fact preempted." *Id.* at 523.

While *Cipollone* discussed the general presumption against preemption, *Cipollone* did not address the issue of whether an agency rule is entitled to judicial deference when application of the rule may result in preemption. That issue was addressed in *Smiley v. Citibank (S. Dakota), N.A.*, 517 U.S. 735 (1996). In *Smiley*, a California resident filed a class action lawsuit alleging that late payment fees charged by a South Dakota bank were "unconscionable" and illegal under California law. *Id.* at 738. The bank argued that the lawsuit was preempted by the definition of "interest" in section 85 of the National Bank Act. *Id.* The agency that administered the act promulgated a rule providing that the term "interest" included late fees. *Id.* The plaintiff asserted that if the term "interest" included late fees, then California law, that allegedly barred such fees, would be preempted. *Id.* As such, the plaintiff argued the agency rule was not entitled to deference and the presumption against preemption applied. *Id.*

The Supreme Court rejected the plaintiff's argument that the presumption against preemption applied because:

> This argument confuses the question of the substantive (as opposed to pre-emptive) *meaning* of a statute with the question of *whether* a statute is pre-emptive. We may assume (without deciding) that the latter question must always be decided *de novo* by the courts. That is *not* the question at issue here; there is no doubt that § 85 pre-empts state law.

Id. at 744. The Supreme Court further emphasized the distinction between the substantive meaning of a statute and the preemptive reach of a statute by noting that "[w]hat is at issue here is simply the meaning of a provision that does not (like the provision in *Cipollone*) deal with pre-emption, and hence does not bring into play the considerations petitioner raises." *Id.*

Smiley indicates that *Chevron* deference does not apply to provisions, "like the provision in *Cipollone*," that deal expressly with preemption, while it does apply to "substantive" provisions even if application of the substantive provision will have some preemptive effect. Like the preemption clause in *Cipollone*, the FEHBA preemption clause is an express preemption clause. Following the distinction between "substantive" and "preemptive" statutory provisions noted in *Smiley*, this Court concludes that there is no binding precedent requiring courts to afford dispositive deference to an agency rule defining the scope of an express preemption clause. Accordingly, this Court declines to hold that the OPM rule conclusive-

ly resolves the ambiguity in the FEHBA preemption clause.[3]

Contrary to this conclusion, Coventry argues that the case law establishes that the OPM rule is entitled to dispositive deference. Coventry argues that *City of Arlington, Tex. v. F.C.C.*, 133 S.Ct. 1863 (2013), indicates clearly that the courts must defer to an agency rule interpreting a preemption clause. The issue in *City of Arlington* was whether "an agency's interpretation of a statutory ambiguity that concerns the scope its regulatory authority (that is, its jurisdiction) is subject to deference under" *Chevron*. *Id.* at 1866. The Supreme Court held that the rule was entitled to deference because:

> *Chevron* is rooted in a background presumption of congressional intent: namely, that Congress, when it left ambiguity in a statute administered by an agency, understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity

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[3] In *Wyeth v. Levine*, 555 U.S. 555, 576 (2009), the Supreme Court "recognized that an agency regulation with the force of law can pre-empt conflicting state requirements." The fact that an agency regulation can have preemptive effect does not mean that courts must defer to an agency rule purporting to define the preemptive scope of a statute administered by the agency. To the contrary, "[i]n such cases, the Court has performed its own conflict determination, relying on the substance of state and federal law and not on agency proclamations of preemption." *Id.* Although *Wyeth* did not directly address the issue of *Chevron* deference, *Wyeth* is consistent with *Cipollone* and *Smiley* insofar as each case indicates that the courts are not required to afford dispositive deference to an agency rule regarding preemption.

> allows. *Chevron* thus provides a stable background rule against which Congress can legislate: Statutory ambiguities will be resolved, within the bounds of reasonable interpretation, not by the courts but by the administering agency.

As Coventry asserts, the Supreme Court's holding and rationale in *City of Arlington* is a strong reaffirmation of *Chevron*. However, *City of Arlington* was not a Supremacy Clause case. Instead, as the Supreme Court made a clear, *City of Arlington* was about the reach of the FCC's regulatory authority. Therefore, *City of Arlington* is, at its core, a Commerce Clause case with the attendant presumption that "legislative Acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality ...." *Hodel v. Indiana*, 452 U.S. 314, 323 (1981) (quoting *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976)). *City of Arlington* does not require this Court to hold that the OPM rule is entitled to *Chevron* deference.

Coventry also asserts that *Cuomo v. Clearing House Association, L.L.C.*, 557 U.S. 519, 531 (2009), holds that Chevron deference applies to express preemption clauses. In *Cuomo*, the issue was whether an agency regulation purporting to pre-empt state law enforcement can be upheld as a "reasonable interpretation of the National Bank Act." *Id.* at 523-524. The Supreme Court noted that *Chevron* deference generally applies to agency regulations. *Id.* at 525. However, as Coventry notes, the Supreme Court did not actually apply *Chevron* deference because the agency's regulation did not comport with the statute. *Id.* at 531. *Cuomo* does not hold that an

agency regulation interpreting an express preemption clause is entitled to *Chevron* deference.

Coventry also cites *Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090 (10th Cir. 2015). In *Helfrich*, the Tenth Circuit held that the same OPM regulation at issue in this case supports a finding that FEHBA preempts state anti-subrogation law. *Id.* at 1110. *Helfrich* reasoned that the presumption against preemption did not apply because the federalism issues that underlie the presumption have "little purchase" when addressing the FEHBA preemption clause because of the federal interest in establishing a uniform set of health insurance benefits for federal employees. *Id.* at 1105. There is no doubt that there is strong federal interest in regulating the provision of health insurance benefits for federal employees. However, it is also true that Missouri has an interest in the uniform enforcement of its anti-subrogation law for all of its citizens. More importantly, even with the federal interest in providing uniform insurance benefits for federal employees, the presumption against preemption still applies because, as indicated in *Empire*, the FEHBA preemption clause is ambiguous and warrants a "cautious interpretation" due to the fact of its "unusual" provision permitting contract terms to preempt state law. 547 U.S. at 697. Respectfully, this Court is not bound by and declines to follow *Helfrich*.

Finally, Coventry notes that in *Kobold v. Aetna Life Ins. Co.*, (Ariz. Ct. App. March 31, 2016), the Court held that the OPM rule at issue in this case is entitled *Chevron* deference. Respectfully, for the reasons noted above, this Court is not bound by and declines to follow *Kobold*.

Conclusion

The OPM rule does not alter the fact that the FEHBA preemption clause does not express Congress' clear and manifest intent to preempt Missouri's anti-subrogation law. The circuit court's judgment in favor of Coventry is reversed, and the case is remanded.

Richard B. Teitelman, Judge

Fischer, Stith, Draper and Russell, JJ., concur; Wilson, J., concurs in result in separate opinion filed; Breckenridge, C.J., Fischer, Stith, Draper and Russell, JJ., concur in opinion of Wilson, J.

SUPREME COURT OF MISSOURI
en banc

JODIE NEVILS,	)	
	)	
Appellant,	)	
	)	
v.	)	No. SC93134
	)	
GROUP HEALTH PLAN, INC., and ACS RECOVERY SERVICES, INC.,	)	
	)	
Respondents.	)	

OPINION CONCURRING IN RESULT

As stated in my separate opinion in *Nevils v. Group Health Plan, Inc.*, 418 S.W.3d 451, 457 (Mo. banc 2014), even if the majority opinion is incorrect and the repayment terms in GHP's contract do fall within the reach of the preemption provision in 5 U.S.C. § 8902(m)(1), that statute's attempt to give preemptive effect to the provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause in article VI of the United States Constitution and, therefore, does not displace Missouri law here. Accordingly, for all of the reasons stated in that separate opinion, I concur in the result reached in the majority opinion in this case.

_____

Paul C. Wilson, Judge

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JODIE NEVILS,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 4:11 CV 588 DDN
	)	
GROUP HEALTH PLAN, INC.,	)	
	)	
	)	
Defendant.	)	

MEMORANDUM AND ORDER OF REMAND

This action is before the court on the motion of plaintiff Jodie Nevils to remand. (Doc. 21.) The parties have consented to the exercise of plenary authority by the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(c). Oral arguments were heard on May 19, 2011.

I. BACKGROUND

On February 9, 2011, plaintiff Jodie Nevils commenced this action on behalf of himself and other similarly situated persons in the Circuit Court of St. Louis County. (Doc. 4.) Defendant Group Health Plan, Inc. removed the case to this court pursuant to federal officer removal jurisdiction, 28 U.S.C. § 1442(a)(1), and pursuant to 28 U.S.C. § 1441(a), based on federal question jurisdiction, 28 U.S.C. § 1331.

According to the complaint, defendant is a private corporate entity that contracts to provide health insurance to individual persons. (Doc. 4 at ¶ 2.) Defendant also contracts with the United States government, through the Office of Personnel Management (OPM), as a "carrier" to administer healthcare benefits in accordance with the Federal Employee Health Benefits Act (FEHBA).[1] (Id. at ¶ 3.)

On November 2, 2006, plaintiff was injured in a motor vehicle accident, and received treatment from numerous healthcare providers. (Id. at ¶¶ 18-19.) Plaintiff brought a personal injury claim against the other driver for his injuries, and the parties reached a settlement to compensate plaintiff for his injuries, medical treatment, pain, and suffering. (Id. at ¶¶ 20-21.) The settlement was paid through the other driver's automobile insurance policy. (Id. at ¶ 21.)

Plaintiff also received medical insurance coverage through a federal health plan, which was governed by FEHBA and for which defendant acted as "carrier" to provide healthcare benefits. (Id. at ¶¶ 22-23.) After paying plaintiff's medical bills arising from the automobile accident, defendant asserted a lien for $6,592.24 for healthcare benefits and services provided to plaintiff related to the automobile accident. (Doc. 4 at ¶¶ 24-25.) On January 29, 2010, plaintiff paid $6,592.24 to defendant through defendant's agent, ACS Recovery. (Id. at ¶ 30.) Thereafter, defendant converted the funds from plaintiff's personal injury settlement. (Id. at ¶ 31.)

Plaintiff asserts four claims on behalf of himself and other persons similarly situated. In Count I,

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[1] The Federal Employees Health Benefits Act of 1959, 5 U.S.C. § 8901, et seq.

plaintiff alleges defendant violated the Missouri Merchandising Practices Act by performing unfair practices and breaching its duty of good faith. (Id. at ¶¶ 40-47.) In Count II, plaintiff alleges defendant was unjustly enriched by unlawfully receiving and retaining the benefits of proceeds to which it was not entitled. (Id. at ¶¶ 48-52.) In Count III, plaintiff asserts a conversion claim for the money paid to defendant. (Id. at ¶¶ 53-57.) In Count IV, plaintiff seeks to enjoin defendant from performing the alleged predatory and unfair practices on consumers such as plaintiff. (Doc. 4 at ¶¶ 58-62.)

II. MOTION TO REMAND

Plaintiff moves to remand the action to state court for lack of subject matter jurisdiction. Plaintiff argues that removal was not permitted under 28 U.S.C. § 1442(a)(1), because defendant was not acting under the direction of a federal officer when it sought subrogation from plaintiff, and because defendant does not have a colorable federal defense. Plaintiff further argues removal is improper under 28 U.S.C. § 1441(a), because FEHBA's preemption provision does not confer subject matter jurisdiction upon the court, and because federal interests in uniformity differ from those interests secured by FEHBA's preemption provision. (Doc. 21.)

Defendant responds that removal is proper under 28 U.S.C. § 1442(a)(1), because it was acting under the direction of OPM, as set forth in the contract between defendant and OPM (OPM-GHP Contract), when it sought subrogation from plaintiff. Defendant also argues that it has a colorable federal defense—that plaintiff's claims are expressly preempted by the terms of the OPM-GHP Contract. Defendant further argues that removal is proper under

28 U.S.C. § 1441(a), because plaintiff's claims implicate federal government interests, and plaintiff's claims present a conflict between federal interests and state law. (Doc. 25.)

Plaintiff replies that subject matter jurisdiction does not exist, because the subrogation provision of the OPM-GHP Contract does not relate to "benefits," and thus cannot preempt contrary state law. Plaintiff also replies that the subrogation provision does not further a federal interest or policy in uniformity. (Doc. 28.)

III. DISCUSSION

A. FEHBA

FEHBA "establishes a comprehensive program of health insurance for federal employees," and authorizes the OPM "to contract with private carriers to offer federal employees an array of health-care plans." Empire HealthChoice Assur., Inc. v. McVeigh, 547 U.S. 677, 682 (2006). See 5 U.S.C. § 8902(a). Thus, "FEHBA assigns to OPM responsibility for negotiating and regulating health-benefit plans for federal employees." Empire, 547 U.S. at 683. FEHBA requires that contracts between OPM and carriers "contain a detailed statement of benefits offered" and allows OPM to "prescribe reasonable minimum standards for health benefits plans ... and for carriers." 5 U.S.C. §§ 8902(d), (e). OPM also has the authority to withdraw approval of a carrier for failing to comply with certain minimum standards. 5 C.F.R. § 890.204.

FEHBA contains one preemption provision, under which "[t]he terms of any contract ... which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to bene-

fits) ... supercede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

FEHBA vests in federal district courts "original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter." 5 U.S.C. § 8912; see Empire, 547 U.S. at 686 (noting that FEHBA contains "but one provision addressed to federal-court jurisdiction").

B. OPM-GHP Contract

The relevant provision of the OPM-GHP Contract states:

> Part II – Benefits
>
> Section 2.5: Subrogation
>
> (a) The Carrier shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members, according to the following rules:
>
> ***
>
> (2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA);

(Doc. 1-3 at 23, Doc 1-4 at 24). The parties agree that this provision is applicable, because defendant subrogates for at least one self-insured plan covered under ERISA (Doc. 1-10, Dickerson Dec. at ¶ 3), and

because under Missouri law, an insurer has no right of subrogation against its own insured. Benton House, LLC v. Cook & Younts Ins., Inc., 249 S.W.3d 878, 882 (Mo. Ct. App. 2008) ("No right of subrogation can arise in favor of an insurer against its own insured, since, by definition, subrogation arises only with respect to rights of the insured against third persons to whom the insurer owes no duty.").

C. 28 U.S.C. § 1442(a)(1)

Title 28 U.S.C. § 1442(a)(1) "grants independent jurisdictional grounds over cases involving federal officers where a district court otherwise would not have jurisdiction." Johnson v. Showers, 747 F.2d 1228, 1229 (8th Cir. 1984).[2] Removal is proper under § 1442(a)(1) when "(1) a defendant has acted under the direction of a federal officer, (2) there was a causal connection between its actions and the official authority, (3) the defendant has a colorable federal defense to the plaintiff's claims, and (4) the defendant is a 'person' within the meaning of the statute." Dahl v. R.J. Reynolds Tobacco Co., 478 F.3d 965, 967

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[2] This section, entitled "Federal officers or agencies sued or prosecuted," states:

> (a) A civil action ... commenced in a State court against any of the following may be removed by them to the district court of the United States for the district and division embracing the place wherein it is pending:
>
> > (1) The United States or any agency thereof or any officer (or any person acting under that officer) of the United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office or on account of any right, title or authority claimed under any Act of Congress for the apprehension or punishment of criminals or the collection of the revenue.

28 U.S.C. § 1442(a)(1).

n.2 (8th Cir. 2007). While the statute as a whole must be liberally construed, Watson v. Philip Morris Cos., Inc., 551 U.S. 142, 147 (2007); Willingham v. Morgan, 395 U.S. 402, 407 (1969), "it must nevertheless be interpreted with the highest regard for the right of the states to make and enforce their own laws in the field belonging to them under the Constitution." Joseph v. Fluor Corp., 513 F. Supp. 2d 664, 673 (E.D. La. 2007). "If the right to remove [under § 1442(a)(1)] is doubtful, the case should be remanded." Dunevant v. Healthcare USA of Missouri, LLC, No. 4:08CV702 FRB, 2008 WL 4066384, at *2 (E.D. Mo. Aug. 27, 2008). The defendant bears the burden of establishing the existence of jurisdiction under § 1442(a)(1). Van Horn v. Arkansas Blue Cross & Blue Shield, 629 F. Supp. 2d 905, 913 (E.D. Ark. 2007).

1. "Acted Under The Direction Of A Federal Officer"

To satisfy the "acted under" requirement, a private person's actions "must involve an effort to assist, or to help carry out, the duties or tasks of the federal superior." Watson, 551 U.S. at 151-52 (emphasis omitted). Further, the federal entity must have exercised "direct and detailed control" over the private party. Culver v. Asbestos Defendants (BP), No. C 10-03484 SI, 2010 WL 5094698, at *5 (N.D. Cal. Dec. 8, 2010). A relationship satisfying the statute's "acting under" requirement will "typically involve[] subjection, guidance, or control." Watson, 551 U.S. at 151-52 (internal quotation omitted). The Supreme Court has cautioned that although "the words 'acting under' are broad, ... broad language is not limitless" and a liberal statutory construction

"can find limits in a text's language, context, history, and purposes." Id. at 147.

Defendant asserts that it was directed to seek subrogation from plaintiff by OPM in the OPM-GHP Contract. See Doc. 1-3 at 23, Doc 1-4 at 24-25. Plaintiff does not dispute that the terms of the OPM-GHP Contract directed defendant to seek subrogation. Compare Doc. 1-3 at 23, Doc. 1-4 at 24 ("The Carrier shall subrogate ...") with Van Horn, 629 F. Supp. 2d at 914 ("[T]he Carrier, in its discretion ..."). Rather, plaintiff challenges whether defendant's compliance with a negotiated contract with OPM is sufficient to satisfy the "acted under" requirement.

In Orthopedic Specialists of New Jersey PA v. Horizon Blue Cross/Blue Shield of New Jersey, 518 F. Supp. 2d 128 (D.N.J. 2007), the court noted that a contract between a carrier and OPM does not necessarily satisfy the "acted under" requirement. Orthopedic Specialists, 518 F. Supp. 2d at 135 n.4. The court explained that FEHBA carriers "freely enter[] into the market, in which ... carriers 'compete vigorously' with other providers for customers within the pool of federal employees." Id. (quoting Houston Cmty. Hosp. v. Blue Cross & Blue Shield of Texas, Inc., 481 F.3d 265, 272 (5th Cir. 2007)). As a result, "OPM does not unilaterally determine what benefits are included in the ... service plan," but rather, "OPM and [the carrier] together *contract* to determine what benefits will be included." Orthopedic Specialists, 518 F. Supp. 2d at 135 n.4 (emphasis in original) (quotations omitted). Therefore, "a provider's duty to abide by contract terms does not necessarily amount to 'control' over the Plan provider." Id.; see also Arnold v. Blue Cross & Blue Shield of

Texas, Inc., 973 F. Supp. 726, 740-41 (S.D. Tex. 1997) ("[The carrier] has offered no evidence to show that its contract negotiations with OPM involve anything other than arms-length bilateral give-and-take."), overruled on other grounds in Winters v. Diamond Shamrock Chem. Co., 149 F.3d 387 (5th Cir. 1998).

The Second Circuit gave a similar account of the FEHBA contract creation process in Empire HealthChoice Assurance, Inc. v. McVeigh, 396 F.3d 136 (2d Cir. 2005), aff'd 547 U.S. 677 (2006). There, the Second Circuit characterized "FEHBA-authorized contracts" as "privately-negotiated contract[s]." Id. at 144. The court explained that "[u]nder FEHBA, the government does not impose contract terms as it would impose a law. Rather, the OPM negotiates the contract terms privately with insurance providers, who are under no obligation to enter into contracts in the first place." Id. (internal citation omitted).

Thus, the relationship between OPM and defendant is not one of "subjection, guidance, or control." Watson, 551 U.S. at 151-52. As a result, defendant's compliance with the terms of the OPM-GHP Contract does not amount to "acting under the direction of a federal officer."

Defendant also contends it was obligated to seek subrogation from plaintiff by 48 C.F.R. § 1609.7001(b)(3), which states:

> (b) [T]he carrier must perform the contract in accordance with prudent business practices. A carrier's sustained poor business practice in the management or administration of a health benefits plan is cause for OPM's withdrawal of approval of the health benefits car-

> rier and termination of the carrier's contract. Prudent business practices include, but are not limited to, the following:
>
> ***
>
> (3) Compliance with the terms of the FEHB Contract, regulations and statutes.

48 C.F.R. § 1609.7001(b)(3). The Supreme Court, however, has definitively stated that compliance with regulations alone does not establish the requisite control, "even if the private firm's activities are highly supervised or monitored." Watson, 551 U.S. at 153. Moreover, 48 C.F.R. § 1609.7001(b)(3) does not require inclusion of the subrogation provision in all contracts between OPM and carriers; it generally requires compliance with contract terms that are agreed upon by OPM and carriers through contract negotiations. See Orthopedic Specialists, 518 F. Supp. 2d at 135 n.4 (noting that "[d]ifferences among plans results from the fact that OPM enters separate negotiations with each carrier") (quotation omitted); Arnold, 973 F. Supp. at 941 (explaining that "OPM does not merely produce a list of benefits for which it requires coverage"); cf. Group Health Inc. v. Blue Cross Ass'n, 587 F. Supp. 887, 891 (S.D.N.Y. 1984) (finding § 1442(a)(1) removal proper because "Medicare fiscal intermediaries act as agents at the sole direction of the Secretary of HHS") (internal quotations omitted).

Therefore, defendant has not satisfied its burden of establishing that it was subject to OPM's direct and detailed control through the OPM-GHP Contract. In the absence of evidence that the subrogation provision was created and included at the direction of OPM, or evidence of a special relationship be-

tween defendant and OPM, defendant's compliance with the OPM-GHP Contract does not satisfy the "acted under" requirement. See Watson, 551 U.S. at 153 (compliance with federal laws, rules, or regulations is not "acting under the direction of a federal official," and "[a] contrary determination would expand the scope of [§ 1442(a)(1)] considerably, potentially bringing within its scope state-court actions filed against private firms in many highly regulated industries").

Because defendant has not satisfied the first requirement for removal under § 1442(a)(1), the court will not address the remaining requirements. See In re Methyl Tertiary Butyl Ether ("MTBE") Prods. Liab. Litig., 488 F.3d 112, 132 (2d Cir. 2007).

D. 28 U.S.C. § 1331

Title 28 U.S.C. § 1331 states that federal district courts "shall have original jurisdiction over all civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331. "A case 'aris[es] under' federal law within the meaning of § 1331 ... if a well-pleaded complaint establishes either that federal law creates the cause of action or that the plaintiff's right to relief necessarily depends on resolution of a substantial question of federal law." Empire, 547 U.S. at 689-90 (internal quotation omitted). Included in the "laws" of § 1331 is federal common law. Nat'l Farmers Union Ins. Cos. v. Crow Tribe, 471 U.S. 845, 850 (1985). "Absent congressional authorization, ... courts may only create federal common law where the operation of state law would (1) 'significant[ly] conflict' with (2) 'uniquely federal interest[s].'" Empire, 396 F.3d at 140-41 (quoting Boyle v. United Techs. Corp., 487 U.S. 500, 507-08 (1988)). This category of cases is "extremely

small." Morgan Cnty. War Mem'l Hosp. v. Baker, 314 Fed. App'x 529, 533 (4th Cir. 2008) (per curiam); see also O'Melveny & Myers v. FDIC, 512 U.S. 79, 87 (1994) (noting that this category of cases is "few and restricted").

Defendant argues that the court has jurisdiction under § 1331 because plaintiff's claims, brought under Missouri law, undermine the federal government's interests in enforcing its contracts, protecting its contractors from liability for complying with its contracts, and the uniform treatment of the carriers with which it contracts.

Defendant's assertion is based on the premise that Missouri law conflicts with the operation of the OPM-GHP Contract. Although Missouri law prohibits subrogation by an insurer against an insured, Benton House, 249 S.W.3d at 882, the Missouri Court of Appeals has stated that "Missouri state law prohibiting subrogation is preempted by the FEHBA." Buatte v. Gencare Health Sys., Inc., 939 S.W.2d 440, 442 (Mo. Ct. App. 1996). Although Missouri courts may wish to revisit this holding in light of subsequent developments of the law, see, e.g., Blue Cross Blue Shield of Illinois v. Cruz, 495 F.3d 510 (7th Cir. 2007) (distinguishing between "benefits" and "financial incident[s]"), Missouri law presently does not appear to conflict with the operation of the OPM-GHP Contract. Blue Cross Blue Shield Health Care Plan of Georgia, Inc. v. Gunter, 541 F.3d 1320, 1322-23 (11th Cir. 2008) (finding no significant conflict between state's complete compensation rule and contrary FEHBA contract terms because the state supreme court "expressly held that the complete compensation rule is not applied when FEHBA is applicable"). "[T]he possibility that at a later stage

in the proceedings, a significant conflict might arise between [Missouri] state law and the federal interests underlying FEHBA" is "insufficient to confer federal jurisdiction." Empire, 396 F.3d at 142.

Therefore, defendant has not established that the court has jurisdiction over the action under § 1331. Because the court lacks subject matter jurisdiction, the case must be remanded to the Circuit Court of St. Louis County for further proceedings.

IV. CONCLUSION

For the reasons set forth above,

IT IS HEREBY ORDERED that the motion of plaintiff Jodie Nevils to remand (Doc. 21) is hereby sustained. The case is remanded to the Circuit Court of St. Louis County for further proceedings.

IT IS FURTHER ORDERED that the motion of defendant Group Health Plan, Inc. for judgment on the pleadings (Doc. 8) is deferred to the Missouri circuit court.

s/ David D. Noce
UNITED STATES MAGISTRATE JUDGE

Signed on June 15, 2011.

APPENDIX C

IN THE CIRCUIT COURT OF THE COUNTY OF ST. LOUIS STATE OF MISSOURI

JODIE NEVILS,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Cause No.
	)	11SL-CC00535
GROUP HEALTH PLAN, INC.	)	
and ACS RECOVERY SER-	)	Division 5
VICES, INC.,	)	
	)	
Defendants.	)	

ORDER AND JUDGMENT

This matter is before the Court on defendants Group Health Plan, Inc.'s [hereinafter "GHP" and ACS Recovery Services, Inc.'s [hereinafter "ACS"] motions for summary judgment. The motions were called, heard and taken under submission on January 27, 2012. The parties appeared by their respective counsel. Having heard the arguments of counsel, having read the statements of facts, memoranda of law and exhibits submitted, and being now duly advised, the Court enters the following Order and Judgment:

The plaintiff, Jodie Nevils, was insured through a federal employee health plan governed by the Federal Employees Health Benefits Act [hereinafter "FEHBA"] and administered by GHP pursuant to a contract with the federal Office of Personnel Man-

agement [hereinafter "OPM"]. Section 2.5 of GHP's FEHBA contract with the OPM, entitled "subrogation" and located in the "Benefits" section of the contract, provided in pertinent part as follows:

> (a) The Carrier [GHP] shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members, according to the following rules:
>
> ***
>
> (2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA).

GHP subrogates in Missouri for at least one ERISA plan. Under the terms of the contract, members who enrolled in or accepted services under the contract were obligated to all its terms, conditions and provisions.

The plaintiff was injured in an auto accident, and his medical bills were paid by the federal health plan. The plaintiff sued the other driver and reached a settlement, against which GHP, through its agent ACS, asserted a lien for $6,592.24. The plaintiff paid the lien and then filed this suit against the defendants.

The plaintiff's First Amended Petition claims the defendants' assertion of a lien violated Missouri's anti-subrogation law. The causes of action include: Count I - violation of the Missouri Merchandising Practices Act; Count II - unjust enrichment; Count III - conversion; and Count IV - injunctive relief. The defendants contend that Missouri's anti-subrogation

law is preempted by FEHBA, which allows for subrogation and reimbursement of payments made for injuries to health plan members caused by third-party tortfeasors.

Summary judgment is designed to permit the trial court to enter judgment, without delay, where the moving party has demonstrated, on the basis of facts as to which there is no genuine dispute, a right to judgment as a matter of law. *ITT Commercial Finance Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371, 381 (Mo. banc 1993).

Missouri courts have declared that it is against the public policy of the state to allow a health insurer a right, by assignment or subrogation, to reimbursement of medical bills it has paid on behalf of its insured for injuries caused by a third-party tortfeasor. *Schweiss v. Sisters of Mercy, St. Louis, Inc.*, 950 S.W.2d 537, 538 (Mo. App., E.D. 1997). However, as noted above, the OPM/GHP contract contained a provision that required GHP to subrogate on FEHBA claims in states where GHP subrogated for at least one ERISA plan.

FEHBA has a preemption clause at 5 U.S.C.A. § 8902(m)(1), which provides as follows:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

Missouri addressed the question of whether § 8902(m)(1)[1] preempts Missouri's anti-subrogation law in *Buatte v. Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. App., E.D. 1996). In that case, the plaintiffs had settled a personal injury case but refused Gencare's request for reimbursement of medical benefits paid by the FEHBA plan it administered. The Court of Appeals held:

> We likewise find that Missouri state law prohibiting subrogation is preempted by the FEHBA. The FEHBA requires preemption of state law if it would differ the "nature or extent of coverage or benefits" offered under the FEHBA authorized plan. In the present case, prohibiting Gencare from seeking reimbursement from its insured would clearly differ the extent of coverage or benefits.

Id. at 442.

The court has thoroughly considered the plaintiff's claims that *Buatte* is no longer good law in light of more recent court decisions. However, no case has overruled *Buatte,* and it is still the law in Missouri. "Where the same or an analogous issue was decided in an earlier case, such case stands as authoritative precedent unless and until it is overruled." *M & H Enterprises v. Tri-State Delta Chemicals, Inc.*, 984 S.W.2d 175, 178 n. 3 (Mo. App., S.D. 1998). Any reconsideration of the *Buatte* holding in light of recent cases would be appropriate in the Court of Appeals. Since Missouri law holds that FEHBA

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[1] An earlier version of § 8902(m)(1) was in effect at the time of the *Buatte* decision. That version included the words "to the extent that such law or regulation is inconsistent with such contractual provisions" at the end of the sentence.

preempts Missouri's anti-subrogation law, the defendants' motions for summary judgment on all counts are granted.

Accordingly, defendant Group Health Plan, Inc.'s Motion for Summary Judgment is GRANTED. Judgment on all counts of plaintiff's First Amended Petition is entered in favor of defendant, Group Health Plan, Inc. and against plaintiff, Jodie Nevils.

Defendant ACS Recovery Services, Inc.'s Motion for Summary Judgment is GRANTED. Judgment on all counts of plaintiff's First Amended Petition is entered in favor of defendant ACS Recovery Services, Inc. and against plaintiff, Jodie Nevils.

SO ORDERED:

May 21, 2012
Date

s/
Thea A. Sherry, Judge

* * *

APPENDIX D

In the Missouri Court of Appeals
Eastern District

DIVISION ONE

JODIE NEVILS,	)	ED98538
	)	
Plaintiff/Appellant,	)	Appeal from the
	)	Circuit Court of
v.	)	St. Louis County
	)	
GROUP HEALTH PLAN, INC. and ACS RECOVERY SERVICES, INC.,	)	Honorable Thea A. Sherry
	)	
	)	
Defendants/Respondents.	)	Filed:
	)	December 26, 2012

Introduction

Jodie Nevils (Appellant) appeals from the trial court's summary judgment in favor of Group Health Plan, Inc. (GHP) and ACS Recovery Services, Inc. (ACS) (collectively Respondents) on Appellant's petition alleging violation of the Missouri Merchandising Practices Act (MMPA); unjust enrichment; conversion, and seeking injunctive relief. We affirm.

Factual and Procedural Background

On November 2, 2006, Appellant, a federal employee, was injured in an automobile accident. As a federal employee, Appellant had medical coverage through a federal employee health benefit plan carried by GHP. GHP paid Appellant's medical bills resulting from the treatment of his injuries. Appellant

subsequently sued the third party tortfeasor responsible for the accident, and recovered a settlement. GHP, through its agent ACS, asserted a lien against Appellant's settlement in the amount of $6,592.24, seeking reimbursement or subrogation for its payment of Appellant's medical bills resulting from the accident. Appellant remitted the $6,592.24 to GHP in satisfaction of the asserted lien, and then on February 9, 2011, filed a class action petition for damages on behalf of himself and others similarly situated against GHP alleging violation of the MMPA; unjust enrichment; conversion; and seeking injunctive relief, all based on the underlying premise that Missouri law does not permit the subrogation of tort claims. GHP filed a Notice of Removal to federal court, asserting that federal question jurisdiction existed under 28 U.S.C. Section 1331, because the federal government's interest in enforcing its contracts conflicted with Missouri anti-subrogation law.

Appellant moved to remand to state court. The United States District Court for the Eastern District of Missouri remanded the case to the trial court, finding no need for federal jurisdiction because Missouri law "presently does not appear to conflict with the operation of the OPM-GHP Contract." OPM is the federal government's Office of Personnel Management, which contracted with GHP for GHP to act as the health insurance carrier for federal employees' health care benefits. The federal court based its decision on this Court's statement that Missouri's anti-subrogation rule is preempted by the Federal Employee Health Benefits Act (FEHBA), 5 U.S.C. Sections 8901-8914, in Buatte v. Gencare Health Sys., Inc., 939 S.W.2d 440, 442 (Mo.App. E.D. 1996). See Nevils v. Group Health Plan, Inc., 2011 WL 8144366 at *6 (E.D. Mo., June 15, 2011) ("Missouri state law

prohibiting subrogation is preempted by the FEHBA.").

On remand, ACS intervened in the action, and on October 31, 2011, Appellant amended his petition to include ACS as a defendant. Respondents filed motions for summary judgment based on Buatte and FEHBA's preemption clause, 5 U.S.C. Section 8902(m)(1). The trial court granted the motions for the reasons stated by Respondents. This appeal follows.

Point on Appeal

In his point on appeal, Appellant contends the trial court erred in granting Respondents summary judgment because FEHBA does not expressly preempt Missouri's anti-subrogation rule, in that asserted rights to subrogation and reimbursement of medical bill payments do not relate to the "nature, provision or extent of coverage or benefits."

Standard of Review

This Court's standard of review for an appeal of the trial court's entry of summary judgment is *de novo*. ITT Commercial Fin. Corp. v. Mid-America Marine Supply Corp., 854 S.W.2d 371, 376 (Mo.banc 1993). We review the record in the light most favorable to the party against whom judgment was entered. Id. Any facts set forth by affidavit or otherwise in support of a party's motion are taken as true unless contradicted by the non-moving party's response to the summary judgment motion. Id. All reasonable inferences are drawn in favor of the nonmovant. Id. After reviewing the evidence in this manner, this Court will only affirm the trial court's entry of summary judgment if the moving party establishes that there is no genuine issue as to the ma-

terial facts and the movant is entitled to judgment as a matter of law. Goerlitz v. City of Maryville, 333 S.W.3d 450, 452 (Mo.banc 2011).

Discussion

Under the Supremacy Clause, state laws and constitutional provisions are preempted and have no effect to the extent they conflict with federal laws. See State ex rel. Proctor v. Messina, 320 S.W.3d 145, 148 (Mo. banc 2010); Johnson v. State, 366 S.W.3d 11, 26-27 (Mo.banc 2012).

Missouri law, as a matter of public policy, does not allow an insurer to acquire part of the insured's rights against a tortfeasor through the payment of medical expense, either by assignment or subrogation. Buatte, 939 S.W.2d at 441-42; Waye v. Bankers Multiple Line Ins. Co., 796 S.W.2d 660, 661 (Mo.App. W.D. 1990). Insurance policies which attempt to do so are, therefore, invalid under state law. Buatte, 939 S.W.2d at 442. Section 2.5 of OPM's FEHBA contract with GHP, titled "Subrogation" and located under "Benefits," purports to allow GHP to acquire part of an insured's rights against a tortfeasor through the payment of medical expense by subrogation as follows:

> (a) The Carrier [GHP] shall subrogate FEHB[A] claims in the same manner in which it subrogates claims for non-FEHB[A] members, according to the following rules:
>
> ...
>
> (2) The Carrier shall subrogate FEHB[A] claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan

> covered under the Employee Retirement Income Security Act of 1974 (ERISA).

Under Section 2.5(a)(2), this subrogation clause is applicable in the instant case because (1) Missouri law prohibits an insurer from subrogation against its own insured, see Benton House, LLC v. Cook & Younts Ins., Inc., 249 S.W.3d 878, 882 (Mo.App. 2008) ("No right of subrogation can arise in favor of an insurer against its own insured, since, by definition, subrogation arises only with respect to rights of the insured against third persons to whom the insurer owes no duty."); and (2) GHP subrogates in Missouri for at least one ERISA plan.

Normally, such a subrogation provision as Section 2.5(a) would be deemed invalid by Missouri courts. However, FEHBA preempts any state law prohibiting subrogation in the manner effected by Respondents against Appellant's settlement award, via the following language:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. Section 8902(m)(1). The contract between OPM and GHP is a "contract under this chapter." Under the terms of the contract, members who enroll in or accept services under the contract, such as Appellant, are obligated to all of its terms, conditions and provisions. Therefore, the preemption clause pertains to this case, both statutorily under Section

8902(m)(1) and contractually pursuant to the insurance policy.

Appellant maintains the preemption clause, although pertinent to this case, should not be applied here because asserted rights to subrogation and reimbursement of medical bill payments do not relate to the "nature, provision or extent of coverage or benefits." However, this Court has already determined this issue to the contrary:

> Although no Missouri cases have addressed the FEHBA's preemption of inconsistent state law, the FEHBA has been found to preempt state law in other jurisdictions. Those courts have enforced subrogation and reimbursement clauses of health plans where state law would not have permitted the same. In NALC Health Benefit Plan v. Lunsford, 879 F.Supp. 760 (E.D.Mich.1995), a U.S. District Court in Michigan upheld a requirement that enrollees reimburse the plan from any third party proceeds they collected, even though under Michigan law such reimbursement would not have been permissible.
>
> Similarly, in Medcenters Health Care v. Ochs, 854 F.Supp. 589 (D.Minn.1993), the insurer sought reimbursement from the insured after the insured had settled with a third party tortfeasor. The Minnesota District Court found that the provisions of the plan permitting such recovery preempted Minnesota state law which would not permit reimbursement unless the insured had received a full recovery.

> We likewise find that Missouri state law prohibiting subrogation is preempted by the FEHBA. The FEHBA requires preemption of state law if it would differ the 'nature or extent of coverage or benefits' offered under the FEHBA authorized plan. In the present case, prohibiting Gencare from seeking reimbursement from its insured would clearly differ the extent of coverage or benefits.

Buatte, 939 S.W.2d at 442. See also Nevils, 2011 WL 8144366 at *6 ("Although Missouri law prohibits subrogation by an insurer against an insured ... the Missouri Court of Appeals has stated that 'Missouri state law prohibiting subrogation is preempted by the FEHBA."). Other jurisdictions have followed Buatte with approval. See, *e.g.*, Thurman v. State Farm Mut. Auto Ins. Co., 598 S.E.2d 448, 451 (Ga. 2004); Aybar v. New Jersey Transit Bus Operations, Inc., 701 A.2d 932, 937 (N.J.Super A.D. 1997), citing Buatte, 939 S.W.2d at 442; NALC, 879 F.Supp. at 763; and Medcenters, 26 F.3d at 867) ("The State presents us with no case dealing with an anti-subrogation provision that holds such a provision is not preempted by FEHBA or ERISA.").

The doctrine of stare decisis directs that, once a court has "laid down a principle of law applicable to a certain state of facts, it [must] adhere to that principle, and apply it to all future cases, where facts are substantially the same; regardless of whether the parties and property are the same." BLACK'S LAW DICTIONARY 1406 (6th ed.1990); Eighty Hundred Clayton Corp. v. Director of Revenue, 111 S.W.3d 409, 412 (Mo.banc 2003). The doctrine of stare decisis promotes security in the law by encouraging adherence to previously decided cases. Independence-

Nat. Educ. Ass'n v. Independence Sch. Dist., 223 S.W.3d 131, 137 (Mo.banc 2007); Watts v. Lester E. Cox Medical Centers, 2012 WL 3101657 *10 (Mo.banc 2012).

Appellant maintains that the district court in Nevils suggested that Missouri courts may want to revisit Buatte's holding "in light of subsequent developments of the law, see, e.g., Blue Cross Blue Shield of Illinois v. Cruz, 495 F.3d 510 (7th Cir. 2007) (distinguishing between "benefits" and "financial incident[s]")." Nevils, 2011 WL 8144366 at *6. Cruz, however, is a federal case from the Seventh Circuit, applying Illinois law, and thus has no precedential value in Missouri. Our own precedent compels this Court to reject Appellant's argument on appeal, as the same argument has already been presented to and rejected by this Court in Buatte.

In any event, even after a careful examination of Cruz, we do not find any development sufficient to question our own holding in Buatte or to find that its holding is incorrect. In Cruz, the FEHBA health insurer sued the insured federal employee seeking reimbursement for benefits paid out of the insured's settlement with the tortfeasor causing his injuries. The United States Court of Appeals for the Seventh Circuit held that no federal-question jurisdiction existed in the insurer's suit against the employee, in response to which the employee asserted Illinois' common fund doctrine, which states that the insurer is responsible for a pro rata share of the employee's attorney's fees. The Court found no unique federal interest in whether the state's doctrine controlled over a contrary term of the insurance contract, since the doctrine affected how much of a tort settlement insured could keep, rather than the amount of bene-

fits he was entitled to. Cruz, 495 F.3d at 513. Thus, Cruz's only holding was that no federal jurisdiction existed over the case.[1]

In Buatte, this Court stated that prohibiting the insurer from seeking reimbursement for its medical coverage expenditures from its federal employee insured's tort suit proceeds based on Missouri's anti-subrogation rule would clearly affect the extent of coverage or benefits. Id. at 442. Although we did not state, in so many words, that the prohibition against subrogation would only affect "how much of the tort proceeds the insured could keep," rather than affect "how many benefits the insured would receive," the import of our words was the same as the import of the words used in Cruz. In the end, each of the insureds in Buatte and Cruz would be remitting some of his tort claim proceeds to his insurer. In Buatte, such remittitur was based on the insurance contract's subrogation clause's preemptive effect on Missouri's anti-subrogation law; and in Cruz, the reimbursement was based on tort proceeds being classified as incidentals rather than benefits and thus preemption over laws affecting benefits was inapplicable. Because Cruz's holding only concerned whether it had federal question jurisdiction and clearly acknowledged that its insured was not going to be able to retain all of his tort claim proceeds but would have to reimburse some to the insurer due to the insurance contract's subrogation clause, the Sev-

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[1] Although the Seventh Circuit distinguished between the word "benefits" as used in FEHBA's subrogation clause and the monies a plaintiff receives from a third-party tortfeasor, which the Court determined to be more appropriately characterized as "financial incidents," this appears to be a distinction without a difference because the Court's ultimate holding did not abrogate FEHBA's preemption of state anti-subrogation law.

enth Circuit's decision does not affect our holding in Buatte that FEHBA preempts Missouri's anti-subrogation law. Therefore, we find no compelling reason to change course from the general dictates of the doctrine of stare decisis and specifically our holding in Buatte. Med. Shoppe Intern., Inc. v. Dir. Of Revenue, 156 S.W.3d 333, 335 (Mo.banc 2005). A decision of this Court should not be lightly overruled, particularly where the opinion is not clearly erroneous and manifestly wrong. Southwestern Bell Yellow Pages, Inc. v. Director of Revenue, 94 S.W.3d 388, 391 (Mo.banc 2002); Eighty Hundred Clayton Corp., 111 S.W.3d at 412.

Appellant also maintains that the United States Supreme Court has likewise distinguished between benefits and reimbursement in Empire Healthchoice Assurance, Inc. v. McVeigh, 547 U.S. 677, 126 S.Ct. 2121, 2132, 165 L.Ed.2d 131 (2006). As in Cruz, the scenario in Empire involved a New York federal employee insured who had recovered damages for his injuries from a state court tort action. The insurer sought reimbursement from the insured's estate for the medical coverage it had provided the insured. The Empire court's holding was solely that federal question jurisdiction was lacking, in that the case did not arise under federal law nor did it involve issues of federal law that belonged in federal court; rather, the insurer's reimbursement claim was triggered not by the action of any federal department, agency, or service, but by the settlement of the personal injury action launched in state court. Empire, 126 S.Ct. 2121, 2129-2130, 2137 (The United States no doubt has an overwhelming interest in attracting able workers to the federal workforce and in the health and welfare of the federal workers upon whom it relies to carry out its functions, but those interests, we

are persuaded, do not warrant turning into a discrete and costly "federal case" an insurer's contract-derived claim to be reimbursed from the proceeds of a federal worker's state-court-initiated tort litigation.). Id. at 2137.

So, here, again, we are presented with the holding of a federal case applying federal law that does not bear upon our conclusion in Buatte, nor does it provide any pertinent or persuasive reasoning that would legitimize a revisit to or reconsideration of Buatte's holding. Rather, the Supreme Court in Empire was merely deciding a jurisdictional issue, which is not even tangentially related to our determination of preemption in Buatte. For these reasons, we reject Appellant's arguments on the basis of the Empire case as well.

Our holding in Buatte, that FEHBA preempts Missouri's anti-subrogation rule because the insurer's right to reimbursement of medical bill payments relates to the nature, provision or extent of benefits provided by the insurer to its federal employee insureds, remains valid. Appellant has failed to present any compelling reason to consider otherwise. Accordingly, his point on appeal is denied.

Conclusion

The judgment of the trial court is affirmed.

s/_____
Sherri B. Sullivan, Judge

Clifford H. Ahrens, P.J., and
Glenn A. Norton, J., concur.

APPENDIX E

SUPREME COURT OF MISSOURI
en banc

Jodie Nevils,	)	
	)	
Nevils,	)	
	)	
vs.	)	No. SC93134
	)	
Group Health Plan, Inc., and ACS Recovery Services, Inc.,	)	
	)	
Respondents.	)	

Appeal from the Circuit Court of St. Louis County
The Honorable Thea A. Sherry, Judge

Opinion issued February 4, 2014

Jodie Nevils (Appellant) filed suit against Group Health Plan, Inc., (GHP) and ACS Recovery Services, Inc., (ACS) (collectively Respondents) after Respondents enforced a subrogation lien against Nevils's settlement of a personal injury claim. The trial court, consistent with *Buatte v. Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. App. 1996), entered summary judgment in favor of Respondents on grounds that 5 U.S.C. section 8902(m)(1) of the Federal Employee Health Benefits Act ("FEHBA") preempts Missouri law prohibiting subrogation. Nevils asserts that FEHBA does not preempt state law barring subrogation of personal injury claims because subrogation does not "relate to the nature, provision, or extent of coverage or benefits." This Court holds that FEHBA does not preempt Missouri law barring subrogation

of personal injury claims. The judgment is reversed, and the case is remanded.

I. Facts

GHP entered into contracts with the federal Office of Personnel Management (OPM) to provide health insurance to federal employees pursuant to FEHBA. The contract directs GHP to seek reimbursement or subrogation when an insured obtains a settlement or judgment against a tortfeasor for payment of medical expenses. Nevils was a federal employee with medical insurance offered through a federal employee health benefit plan carried by GHP.

Nevils was injured in an automobile accident. GHP paid Nevils's resulting medical bills. Nevils then recovered a personal injury settlement from the tortfeasor responsible for the accident. GHP, through its agent ACS, asserted a lien against Nevils' settlement in the amount of $6,592.24, seeking reimbursement or subrogation for its payment of Nevils' medical bills resulting from the accident. Nevils satisfied the lien.

Nevils filed a class action petition for damages on behalf of himself and others similarly situated against GHP alleging violation of the Missouri Merchandising Practices Act; unjust enrichment; conversion; and seeking injunctive relief. All claims were based on the premise that Missouri law does not permit the subrogation of tort claims. GHP removed the case to federal court. Nevils filed a motion to remand the case to state court. The federal district court sustained Nevils' motion on the ground that there was no federal jurisdiction because *Buatte* held that the FEHBA preempts Missouri law barring subrogation.

Following remand to the state court, ACS intervened in the case. Respondents filed a motion for summary judgment. Respondents, relying on *Buatte*, asserted that FEHBA preempted Missouri's anti-subrogation law. The trial court entered judgment for Respondents. This appeal followed.

II. Standard of Review

Nevils' sole point on appeal asserts that the trial court erred in entering summary judgment in favor of Respondents because FEHBA does not preempt Missouri law barring subrogation of personal injury claims. This Court's standard of review for an appeal of a summary judgment regarding a legal issue is de novo. *ITT Commercial Fin. Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371, 376 (Mo. banc 1993).

III. Analysis

Missouri law generally prohibits subrogation in personal injury cases by barring insurers from obtaining reimbursement from the proceeds an insured obtains following a judgment against a tortfeasor. *See Benton House, LLC v. Cook & Younts Ins., Inc.*, 249 S.W.3d 878, 882 (Mo. App. 2008). Subrogation in personal injury cases is considered to be against public policy because it amounts to an impermissible assignment of the insured's right to a cause of action for suffering a personal injury. *See Hays v. Mo. Highways & Transp. Comm'n*, 62 S.W.3d 538, 540 (Mo. App. 2001). Therefore, insurance policies with reimbursement or subrogation clauses are invalid under Missouri law. *Buatte*, 939 S.W.2d at 442.

Although Missouri law generally prohibits subrogation of personal injury claims, FEHBA's preemp-

tion clause, 5 U.S.C. section 8902(m)(1), applies to this case and provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

Resolution of the issue in this case requires this Court to determine whether Respondents' asserted right to subrogation "relate[s] to the nature, provision or extent of coverage or benefits."

The Supremacy Clause of the United States Constitution provides that state laws and constitutional provisions are preempted when in conflict with federal laws. *See Johnson v. State*, 366 S.W.3d 11, 26-27 (Mo. banc 2012). Consideration of issues arising under the Supremacy Clause "start[s] with the assumption that the historic police powers of the States [are] not to be superseded by ... Federal Act unless that [is] the clear and manifest purpose of Congress." *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504 (1992). When a federal statute regulates an area that is traditionally subject to state authority, courts "should be reluctant to find preemption." *CSX Transp., Inc., v. Easterwood,* 507 U.S. 658, 664 (1993). Preemption analysis, therefore, "is informed by two presumptions about the nature of preemption." *City of Belton v. Smoky Hill Ry. & Historical Soc., Inc.,* 170 S.W.3d 429, 434 (Mo. App. 2005), quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). First, it is presumed that the states' historic police powers are not preempted unless it is the clear intent of Congress. *Id.* Second, a court's analysis of the scope of a stat-

ute's preemption is determined by the congressional purpose in enacting the statute. *Id.* When two plausible readings of a statute are possible, "we would nevertheless have a duty to accept the reading that dis-favors preemption." *Bates v. Dow AgroSciences, LLC,* 544 U.S. 431, 449 (2005).

In *Buatte*, the Missouri court of appeals held that FEHBA preempted Missouri's law against subrogation because the insurer's right to reimbursement of paid medical bills relates to the "nature, provision, or extent of coverage or benefits." *Buatte*, 939 S.W.2d at 442. The *Buatte* court reasoned that "prohibiting [the carrier] from seeking reimbursement would clearly differ the extent of coverage or benefits." *Id.* *Buatte* rested on the premise that subrogation "relates to" the insurance coverage and benefits. Other jurisdictions have followed the *Buatte* rationale. *See, e.g., Thurman v. State Farm Mut. Auto. Ins. Co.,* 278 Ga. 162, 598 S.E.2d 448, 451 (Ga. 2004); *Aybar v. New Jersey Transit Bus Operations, Inc.,* 305 N.J.Super. 32, 701 A.2d 932, 937 (N.J. 1997).

The continued validity of *Buatte* is called into question by the United States Supreme Court's decision in *Empire Healthchoice Assurance Co. v. McVeigh*, 547 U.S. 677, 698 (2006). In *Empire,* the Supreme Court held that the FEHBA preemption provision did not provide for complete preemption of state law so as to confer federal jurisdiction and, as a result, an insurance carrier's claims raised only state law issues. *Id.* The issue in *Empire* was whether FEHBA completely preempted state law in all insurance carrier disputes arising under the statute. Although the Supreme Court expressly declined to determine whether the statute preempts state subroga-

tion laws two aspects of the Supreme Court's analysis are relevant to Nevils' claim.

First, *Empire* recognized that the FEHBA preemption clause is subject to plausible, alternate interpretations. *Id.* at 697. The Supreme Court noted that the clause "was open to more than one construction" and its "words may be read to refer to contract terms relating to the beneficiary's entitlement (or lack thereof) to [the insurance plan's] payment for certain health-care services [the beneficiary] has received, and not to terms relating to the carrier's post-payments right to reimbursement." *Id.* at 698. The Supreme Court also noted that the "choice-of-law prescription is unusual in that it renders [superior] preemptive contract terms in health insurance plans, not provisions enacted by Congress[]" and that such an "unusual order warrants [a] cautious interpretation." *Id.* *Empire* establishes that the FEHBA preemption clause is susceptible to reasonable, alternate interpretations. The fact that the preemption clause is susceptible to alternate interpretations implicates the presumption against preemption noted in *Bates,* in which the Supreme Court noted that when two plausible readings of a statute are possible, "we would nevertheless have a duty to accept the reading that dis-favors preemption." *Bates,* 544 U.S. at 449 (2005).

Second, the Supreme Court distinguished the provision of insurance coverage and benefits to an insured from an insurer's right to subrogation. Specifically, the Supreme Court noted that while FEHBA contains a preemption clause displacing state law on issues relating to coverage and benefits, FEHBA "contains no provision addressing the subrogation or reimbursement rights of carriers." *Id.* at

683. This distinction is important because *Buatte* is premised on the conclusion that, pursuant to the FEHBA preemption clause, an insurer's contractual right to subrogation under a FEHBA insurance plan relates to "the nature, provision, or extent of coverage or benefits." If an insured's coverage and benefits are separate from the insurer's contractual right to subrogation, then the right to subrogation does not "relate to" coverage and benefits and state subrogation law is not preempted.

The distinction between insurance benefits and subrogation was further explained in *Blue Cross Blue Shield of Illinois v. Cruz*, 495 F.3d 510 (7th Cir.2007), where the court noted that *Empire* "distinguished ... between benefits and reimbursement" and reasoned that the amount of benefits to which an insured is entitled is established by the insurance contract while state law regarding subrogation simply affects the amount of a tort judgment the plaintiff gets to keep and how much he or she must give the insurer. *Id.* at 512. Following this rationale, the court then noted that if the term "benefits" as used in the FEHBA preemption clause is understood to include every financial incident of an illness or injury, then "national uniformity is unattainable without a federal takeover of the entire tort system." *Blue Cross Blue Shield of Ill. v. Cruz ("Cruz II")*, 495 F.3d 510, 514 (7th Cir. 2007).

Empire and *Cruz* are not dispositive because both cases held only that there was no federal jurisdiction arising from complete preemption of state law. As noted above, however, *Empire* counsels a "cautious" interpretation of the FEHBA preemption clause and both cases established a distinction between the insured's coverage and benefits and the

insurer's right to subrogation. In addition to the presumption against preemption, this Court's analysis of whether FEHBA preempts Missouri's law of subrogation must assess GHP's right to subrogation with these considerations in mind.

The FEHBA preemption clause provides that contract terms that "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" preempt state law. The operative terms are "relate to," "coverage" and "benefits." *See Kobold v. Aetna Life Ins., Co.*, 309 P.3d 924, 927 (Ariz. App. 2013)(holding that FEHBA does not preempt Arizona law barring subrogation of personal injury claims).

The term "relate to" generally means "having a connection with." *Kobold*, 309 P.3d at 927, citing, *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 394 (9th Cir. 2002)(interpreting latter half of the FEHBA preemption clause, which provides for preemption of any state law that "relates to" health insurance or plans). When considered in conjunction with *Empire's* "cautious interpretation" and the presumption against preemption, the term "relate to" cannot be given a broad, literal interpretation.[1] A broad interpretation of "relate to" would "extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere.'" *Kobold*, 309 P.3d at 927, citing *Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847,

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[1] The presumption against preemption and the attendant requirement of a more narrow interpretation distinguishes the analysis in this case from broader interpretations of the term "relate to" that may be utilized in cases involving a remedial statute.

849-50 (9th Cir. 2002) (quoting *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)). The term "relate to," therefore, must be construed as requiring a direct and immediate relationship to the insurance coverage and benefits at issue. *Kobold*, 309 P.3d at 927.

The term "coverage" means the scope of the risks insured under a plan or policy. Black's Law Dictionary 394 (8th ed. 2004) (defining "coverage" as "[i]nclusion of a risk under an insurance policy; the risks within the scope of an insurance policy"). Therefore, the extent of Nevils' "coverage" consists of the various risks GHP agreed to insure. Nothing in the subrogation provision in the insurance contract affects the extent of insurable risk that GHP accepted. Further, subrogation necessarily occurs after the "coverage" issue is resolved, so subrogation cannot affect the extent, nature or provision of insurance "coverage." The scope of Nevils' insurance coverage is neither expanded nor curtailed by requiring him to reimburse GHP from the proceeds of Nevils' personal injury settlement. As such, subrogation does not relate to GHP's "coverage" of Nevils' risk of illness or accident. *See Kobold*, 309 P.3d at 928.

Finally, the term "benefits" means the financial assistance that the insured receives as a consequence of the coverage. Black's Law Dictionary 167 (defining "benefit" as "[f]inancial assistance that is received from ... insurance ... in time of sickness, disability, or unemployment"). As noted in *Empire* and *Cruz*, an insured's "benefits" are distinct from the insurer's right to pursue subrogation against the insured's recovery from a third party tortfeasor. In this context, the term "benefits" includes payments by the insurance carrier on behalf of the insured, not

payments to the insured by third parties. The "benefits" to which Nevils was entitled under the insurance plan provided by GHP were not dependent on recovery from a third party. The fact that GHP's contractual right to reimbursement is triggered by the payment of benefits does not mean that it "relate[s] to the nature, provision, or extent of" benefits. *Kobold*, 309 P.3d at 928. This is illustrated, in part, by the fact that Nevils would have been entitled to the same benefits had he never filed suit to recover damages for his injuries. *Id.* GHP's right to subrogation affects the parties' net financial position after the provision of insurance benefits pursuant to the coverage provided in the insurance contract, but it does not affect the scope of coverage or the receipt of benefits. The fact that GHP's contractual right to reimbursement is triggered by the payment of benefits does not mean that it "relate[s] to the nature, provision, or extent of" benefits. *Id.*, citing *Cruz*, 495 F.3d at 514.

The subrogation provision in favor of GHP creates a contingent right to reimbursement and bears no immediate relationship to the nature, provision or extent of Nevils' insurance coverage and benefits. Contrary to the holding in *Buatte,* this Court holds that FEHBA does not preempt Missouri law barring

subrogation of personal injury claims.[2] The judgment is reversed, and the case is remanded.

Richard B. Teitelman, Judge

Russell, C.J., Fischer, Stith and Draper, JJ., concur; Wilson, J., concurs in separate opinion filed; Breckenridge, J., concurs in opinion of Wilson, J.

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[2] Respondents also assert that an OPM "carrier letter" issued in June 2012 is entitled to "substantial deference" pursuant to *Chevron USA, Inc., v. Natural Resources Defense Counsel, Inc.*, 467 U.S. 837 (1984). The OPM letter reiterates the agency's position that FEHBA preempts state anti-subrogation rules. Under *Chevron*, an agency has the power to form policy and make necessary rules when the statute is either silent or ambiguous on an issue. *Id.* 842-43. However, "*Chevron* deference" is typically applied "where an agency rule sets forth important rights and duties, where the agency focuses fully and directly on the issue, where the agency uses notice and comment procedures to promulgate a rule, [and] where the resulting rule falls within the statutory grant of authority." *Long Island Care at Home, Ltd. v. Cole*, 551 U.S. 158, 173 (2007). The OPM carrier letter is recent, informal and was drafted in response to litigation challenging the subrogation provision in its contract. While informal agency interpretations of statutes are relevant, there is no indication that Congress delegated to the OPM the authority to make binding interpretations of the scope of the FEHBA preemption clause. The OPM letter is not entitled to the deference described in *Chevron* and does not establish that FEHBA preempts state anti-subrogation law. *See Kobold*, 309 P.3d at 929.

SUPREME COURT OF MISSOURI

en banc

Jodie Nevils,	)	
	)	
Appellant,	)	
	)	
vs.	)	No. SC93134
	)	
Group Health Plan, Inc., and ACS Recovery Services, Inc.	)	
	)	
Respondents.	)	

CONCURRING OPINION

Missouri law prohibits a health care insurer from demanding that the insured repay benefits received before the insured recovers from his tortfeasor. GHP contends that Jodie Nevils lost the protection of Missouri law in this regard when he went to work for the federal government. GHP's argument is based on the language of the Federal Employee Health Benefits Act ("FEHBA"), 5 U.S.C. § 8902(m)(1), which purports to subordinate certain aspects of Missouri law not to any federal law but to contract terms negotiated between GHP and the federal Office of Personnel Management ("OPM").

The majority opinion concedes the preemptive power asserted in § 8902(m)(1) and so rejects GHP's argument only by finding that the benefit repayment terms in GHP's contract fail the relatedness test set forth in that statute. I disagree because the conclusion that contract terms requiring Nevils to repay benefits already received are not related to the nature and extent of Nevils' benefits (and are not relat-

ed to payments regarding his benefits) is based on the sort of hyper-technical approach that this Court otherwise steadfastly refuses to employ when construing insurance contracts. I do not dissent, however, because I would hold that the preemption language in § 8902(m)(1) is not a valid application of the supremacy clause in article VI of the Constitution of the United States; as a result, it has no effect. Accordingly, FEHBA presents no bar to Nevils' suit, and I concur with the majority opinion that the trial court judgment should be vacated and the case remanded for further proceedings.[1]

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[1] GHP earlier attempted to remove this case to federal court under 28 U.S.C. § 1441 (federal question removal) because Nevils' claims arise under federal law and under 28 U.S.C. § 1442(a)(1) (federal officer removal) because GHP was acting at the direction of OPM in requiring Nevils to repay the GHP benefits he had received. The district court denied both grounds and remanded the case to state court. *Nevils v. Group Health Plan, Inc.*, No. 4:11 CV 588 DDN (E.D.Mo. June 15, 2011) (2011 WL 8144366). However, the district court's reasoning regarding federal officer removal later was rejected by the Eighth Circuit, which found removal proper because insurers exercise delegated authority under FEHBA. *Jacks v. Meridian Res. Co., LLC*, 701 F.3d 1224, 1234 (8th Cir. 2012) (citing and rejecting district court's decision in *Nevils*). And, on the second ground, the district court denied removal under the federal question statute because "Missouri law presently does not appear to conflict with the operation of the OPM–GHP Contract." *Nevils*, 2011 WL 8144366 at *6 (citing *Buatte v. Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. App. 1996)). Though the district court foretold that *Buatte* would be overruled as wrongly decided, it held that federal jurisdiction could not be premised on the possibility that a conflict between state and federal law might arise later in the case. *Id.* But now that this Court has overruled *Buatte*, federal question jurisdiction may exist. In rejecting federal court jurisdiction in *McVeigh*, the Supreme Court was careful to restrict its determination to the procedural con-

I. Background

Nevils was injured in a car wreck and, as a result, incurred medical bills in excess of $6,600. Those bills were paid by GHP, which managed the health insurance plan for Nevils and other federal employees in Missouri according to terms negotiated between GHP and the "OPM".[2] When Nevils later

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text before it, i.e., where the insurer sued to enforce its contractual right to subrogation. The Court held that such a claim involved no rights established by Congress or federal common law and that a federal question would arise, if at all, only as a defense to the insurer's claim. Under the "well pleaded complaint" rule, federal question jurisdiction cannot be predicated on an anticipated federal defense. But here, even though Nevils is asserting state law claims, a necessary element of his claims is that GHP had no right to the reimbursement it demanded and obtained. That element plainly depends upon the application (and validity) of § 8902(m)(1). This question of federal law is an essential part of Nevils' claims, not merely an anticipated defense.

[2] GHP is not an insurer in the ordinary sense because it bears no risk regarding Nevils' health care plan. Instead, all of the risk is borne by the United States, and GHP merely manages the plan for a fee. *Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 703 (2006) (Breyer, J., dissenting). GHP's management duties are set out in its contract with OPM, and this contract also establishes the nature and extent of the employee benefits provided, as well as the circumstances in which the employee must repay those benefits. *Id.* The premiums paid by the government and its employees are held by the United States, not GHP, and are used to pay claims processed by GHP and the other third-party managers ("TPMs"). The proceeds of the benefit repayment terms at issue in this case, and those from similar terms allowing GHP to pursue an enrollee's claims as a subrogee, are not retained by GHP. Instead, they are paid into this same fund and used by the United States to cover premium shortfalls, rebate premiums already paid, reduce future premiums, or increase plan benefits. *Id.* Oddly, GHP does not argue that its role as a TPM (and not as an in-

settled his claim against the driver whose negligence caused Nevils' injuries, GHP demanded that Nevils repay the $6,600 so that GHP did not end up having to pay – and Nevils did not end up receiving – the benefits promised under the plan. Nevils repaid the $6,600.

If Nevils had been paying for health care coverage from GHP while working for any employer in Missouri other than the federal government, GHP would not have been allowed to reduce Nevils' benefits by $6,600 merely because he recovered from his tortfeasor. All parties agree that Missouri law renders void as a matter of public policy any contract provision purporting to give the insurer the right to such repayment. *See, e.g., Schweiss v. Sisters of Mercy*, 950 S.W.2d 537, 538 (Mo. App. 1997) (rejecting as "a distinction without a difference" the argument that "the reimbursement provision at issue in this case is different from [a subrogation provision] because it involves the assignment of the *proceeds*, not an assignment of the *claim*.") (emphasis in the original).[3]

But, in this case, GHP contends that the shoe is on the other foot. Here, GHP claims that it is the

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surer) should have any affect on the analysis. Nor does GHP argue that the repayment terms at issue here should be treated as benefiting – and, therefore, should be treated as being exercised by – the United States and not GHP.

[3] The Supreme Court, too, refused to distinguish between terms requiring subrogation and terms requiring employees to repay benefits received before the employee recovered from a third party. *McVeigh*, 547 U.S. at 693 (noting that federal common law could not displace state tort law governing an insurer's subrogation claim against the tortfeasor and finding no reason "why the two linked provisions – reimbursement and subrogation – should be decoupled").

terms of its contract with OPM that render Missouri law void, not the other way around. GHP's argument is based upon a provision in FEHBA that governs Nevils' health insurance plan:

> The ***provisions of any contract under this chapter*** which relate to the nature or extent of coverage or benefits (including payment with respect to benefits) ***shall supersede and preempt any State or local law***, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1) (emphasis added).[4]

II. § 8902(m)(1) applies and purports to preempt applicable Missouri law

The majority opinion concedes that, under § 8902(m)(1), the benefit repayment terms in GHP's contract "supersede and preempt" Missouri's law prohibiting them if – but only if – those terms "relate to the nature or extent of [Nevils'] coverage or benefits (including payment with respect to [his] benefits)." Accordingly, the majority opinion preserves the primacy of Missouri law only by declaring that benefit repayment terms have no relationship to the nature or extent of Nevils' benefits and no relationship to payments regarding his benefits. No matter how lenient the "blush test," this construction cannot pass muster.

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[4] A final clause reading: "to the extent that such law or regulation is inconsistent with such contractual provisions," was removed by Congress in 1998. Accordingly, "under § 8902(m)(1) as it now reads, ***state law*** – whether consistent or inconsistent with federal [contract terms] – ***is displaced on matters of 'coverage and benefits.'***" *Empire HealthChoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 686 (2006) (emphasis added).

The majority opinion's construction of the GHP contract uses the type of form-over-substance approach that this Court ordinarily disdains when construing insurance contracts. Here, one part of the GHP contract plainly promises Nevils certain benefits (i.e., payment for covered medical expenses) while another part of the contract takes those benefits away by requiring him to repay these benefits if Nevils later recovers from a third party. This is the classic "give with one hand and take with the other" approach this Court ordinarily decries as a patent ambiguity. *See Behr v. Blue Cross Hosp. Serv., Inc., of Missouri*, 715 S.W.2d 251, 256 (Mo. banc 1986) ("If a contract promises something at one point and takes it away at another there is an ambiguity.") (citing *Lutsky v. Blue Cross Hospital Serv. Inc.*, 695 S.W.2d 870, 875 (Mo. banc 1985)). *See also Todd v. Missouri United Sch. Ins. Council*, 223 S.W.3d 156, 163 (Mo. banc 2007) (noting that *Behr* and *Lutsky* "involved contracts containing contradictory or necessarily inconsistent language in different portions of the instrument").

Leaving aside for the moment the issues of preemption and Missouri's prohibition against benefit repayment terms, if this suit was an action like *McVeigh* in which GHP sought to enforce its contractual right to repayment from Nevils, the Court surely would conclude that GHP's contract contains contradictory and conflicting terms, just as it did in *Behr* and *Lutsky*. Because terms cannot contradict or conflict one another unless they relate to the same subject, it defies logic to insist that benefit repayment terms do not ***relate*** to the nature or extent of Nevils' benefits. But even if that debate continues, surely everyone would concede that terms requiring Nevils to ***pay*** benefits back to GHP that GHP previously

had ***paid*** out are terms that relate to "payment with respect to [Nevils'] benefits."

The alternative conclusion that benefit repayment terms are unrelated to benefits because performance of the latter usually is complete before the former are invoked can only be correct as a purely academic exercise. *See Blue Cross Blue Shield of Illinois v. Cruz*, 495 F.3d 510, 514 (7th Cir. 2007) ("the *benefits* are uniform, though the net financial position of an insured who has a potential tort claim is not") (emphasis in original). But this Court usually does not adopt such a stilted construction. *See Seeck v. Geico Gen. Ins. Co.*, 212 S.W.3d 129, 132 (Mo. banc 2007) (when "construing the terms of an insurance policy, this Court applies the meaning which would be attached by an ordinary person of average understanding if purchasing insurance") (quotation marks omitted); *Robin v. Blue Cross Hosp. Serv., Inc.*, 637 S.W.2d 695, 698 (Mo. banc 1982) ("language used [in insurance contract] will be viewed in light of the meaning that would ordinarily be understood by the layman who bought and paid for the policy") (quotation marks omitted). Here, any ordinary insured would understand that benefit repayment terms are ***related*** to benefits because he does not care what his "benefits" are if he will not be allowed to keep them. As the Court recognized in *Behr* and *Lutsky*, the insured is concerned with the combined effect of conflicting terms. In other words, to the insured, it is not what you get that matters but what you get to keep.

Of course, this suit is not like *McVeigh*. It was initiated by Nevils, not GHP. After repaying the $6,600 in benefits previously received, Nevils brought common law and statutory consumer fraud

claims against GHP based upon its demand that Nevils (and a purported class of other insureds) make the repayments that GHP's contract plainly requires but that Missouri law ordinarily does not allow. But if the terms are related to benefits or payments – and plainly these are – they are related, regardless of which party wants (or does not want) them to be. Accordingly, I cannot join the reasoning of the majority opinion and would hold, instead, that the benefit repayment terms in GHP's contract plainly are related to the nature and extent of Nevils' benefits and, even more plainly, are related to "payment with respect to [Nevils'] benefits" because these terms actually require such a payment.

The majority opinion may have been persuaded by GHP's argument that the Supreme Court's decision in *McVeigh* suggests that the relationship between benefit repayment terms and benefits (or benefit payments) is uncertain and, therefore, not clear enough to overcome the presumption against preemption. This is not what *McVeigh* says, nor is it what this case means. *McVeigh* was concerned with whether federal courts have jurisdiction over a FEHBA insurer's contractual right to a benefit repayment, not with whether § 8902(m)(1) applies to such contract terms and preempts state laws that would prohibit them. Accordingly, the analysis in *McVeigh*, including the analysis on which GHP relies, occurs solely in the context of 29 U.S.C. § 1331 and whether that insurer had shown "either that federal law creates the [insurer's] cause of action or that the [insurer's] right to relief necessarily depends on resolution of a substantial question of federal law." *Id.* at 690 (quotation marks omitted).

The Supreme Court noted that nothing in FEHBA creates – or even mentions – the insurer's right to demand repayment of benefits. *Id.* at 696-97 (insurer's claim based solely on contract terms, not FEHBA). Thus, not only did the insurer's claim not arise out of FEHBA or any other federal statute, it also did not depend on the resolution of a federal law question.[5] Accordingly, if federal jurisdiction were to exist in *McVeigh*, it would only be because the insurer's claim arose under (and was controlled by) previously undetected federal common law in the area of federal employee health benefits so pervasive the

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[5] Under the "well-pleaded complaint" rule, federal court jurisdiction cannot be based on federal questions that are not raised by the plaintiff and will arise (if at all) only as a result of the defendant's answer. *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392-93 (1987). Therefore, in *McVeigh*, it was irrelevant for jurisdictional purposes that the insured likely would defend the insurer's repayment claim by asserting New York's prohibition of such terms in insurance contracts, even though that would result in a debate over whether § 8902(m)(1) preempts the insured's state law defense. This reasoning does not apply here, however, because this case was brought by Nevils, not the insurer. GHP's earlier efforts to remove this case were unsuccessful because the district court found that Nevils' claim did not depend on the resolution of a disputed federal issue because "Missouri law presently does not appear to conflict with the operation of the OPM–GHP Contract." *Nevils v. Group Health Plan, Inc.*, No. 4:11 CV 588 DDN (E.D.Mo. June 15, 2011) (2011 WL 8144366, at *6) (citing *Buatte*). Now that *Buatte* has been overruled, however, the inapplicability (or invalidity) of § 8902(m)(1) is a federal law question essential to Nevils' claims and not just to an anticipated defense, as in *McVeigh*. In addition, the district court's rationale for rejecting GHP's alternative removal claim under 28 U.S.C. § 1442(a)(1) has been rejected by the Eighth Circuit. *See Jacks v. Meridian Res. Co., LLC*, 701 F.3d 1224, 1234 (8th Cir. 2012) (citing and rejecting district court's decision in *Nevils*).

Supreme Court reasonably could infer that Congress intended to allow federal court jurisdiction.

Accordingly, the only purpose for which *McVeigh* considers § 8902(m)(1) is to see whether that statute supports an inference that Congress intended to overthrow not just isolated aspects of state law but the entire body of state law that may affect federal employee health benefits. The Supreme Court found the statute inadequate for this purpose.

> [§ 8902(m)(1)] is not sufficiently broad to confer federal jurisdiction. If Congress intends a preemption instruction completely to displace ordinarily applicable state law, and to confer federal jurisdiction thereby, it may be expected to make that atypical intention clear. Congress has not done so here.

Id. at 698.

The Court later reaffirmed this holding, stating that the insurer failed to "establish that § 8902(m)(1) leaves no room for any state law potentially bearing on federal employee-benefit plans in general, or carrier-reimbursement claims in particular" and, therefore, "§ 8902(m)(1) [contains] no prescription for federal-court jurisdiction." *Id.* at 699 (emphasis added). *See also Empire HealthChoice Assur., Inc. v. McVeigh*, 396 F.3d 136, 150 (2d Cir. 2005) *aff'd.* 547 U.S. 677 (2006) ("The preemption provision [§ 8902(m)(1)] does not manifest an intent to supplant all state law with federal common law in cases involving FEHBA-authorized contract provisions.")

In light of the context in which the Supreme Court was evaluating § 8902(m)(1), it is clear that the Court's statements regarding the uncertain reach of the statute had nothing to do with whether the

Court believed Congress intended for contractual benefit repayment terms to preempt state law prohibitions of such terms. Instead, those statements reflected only the Court's conclusion that § 8902(m)(1) fails to demonstrate any clear congressional intent to replace the entire body of state law with federal common law. To suggest, as GHP does, that the Supreme Court was indicating that the statute may not apply to benefit repayment terms is a misuse of *McVeigh*.[6]

For the reasons stated above, I would hold that Congress plainly intended for § 8902(m)(1) to give preemptive effect to contract terms between OPM and private insurance companies so that terms that

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[6] GHP's reliance on *Blue Cross Blue Shield of Illinois v. Cruz*, 495 F.3d 510 (7th Cir. 2007), also is misplaced. The majority opinion quotes *Cruz* as saying that the Supreme Court in *McVeigh* "distinguished ... between benefits and reimbursement." *Id.* at 513. But *Cruz* makes this comment in the context of recounting the Supreme Court's fruitless search for a basis to infer that Congress intended to displace the entire body of state law in this area with federal common law. The two sentences in *Cruz* immediately before the sentence quoted in the majority opinion make this clear:

> The jurisdictional holding in our previous opinion was based on a belief that Congress in the Federal Employees Health Benefit Act had wanted federal employees to have ***the same benefits under their health plan no matter what state they were in***, so that if they moved from one state to another they would not have to worry that their entitlement had changed. ***That was an argument for regulating the contracts between the insurers and the government by a uniform body of contract principles, and thus by a federal common law of contracts.*** The Supreme Court distinguished, however, between benefits and reimbursement.

Id. at 513 (emphasis added).

require federal employees to repay health insurance benefits received before the employee recovers from the tortfeasor will "supersede and preempt" state laws prohibiting such terms.[7]

III. § 8902(m)(1)'s attempt at preemption is ineffective

Even though Congress plainly intended for § 8902(m)(1) to apply to the benefit repayment terms in GHP's contract and give such terms preemptive effect, I do not concede that Missouri law must bow to those terms. The idea that Congress claims the power to authorize the executive branch and private insurance companies to negotiate contract terms that Congress decrees – sight unseen – shall "preempt and supersede" state law is such an unprecedented and unjustified intrusion on state sovereignty that it almost defies analysis. *See Arthur D. Little, Inc. v. Comm'r of Health & Hospitals of Cambridge*, 481 N.E.2d 441, 452 (Mass. 1985) ("this court has been unable to locate authority in this or any other jurisdiction which supports the proposition that a contract to which the Federal government is a party

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[7] To be clear, I would hold that benefit repayment terms not only meet the relatedness test in § 8902(m)(1) in that they relate to the nature or extent of Nevils' benefits (and to payments regarding his benefits), I would hold that Missouri's prohibition against such terms meets the statute's second test requiring that the state law being preempted must "relate[] to health insurance or plans." Nevils does not contest the applicability of this second test, nor could he. Missouri's common law prohibition against terms giving insurers a right to repayment of benefits may be based in the broader policy against subrogation or assignment of personal injury claims, but this well-established prohibition applies directly – not merely incidentally – to "health insurance or plans."

somehow constitutes Federal law for the purposes of the supremacy clause").

To be sure, the supremacy clause declares that "the laws of the United States ... shall be the supreme law of the land; and the judges in every state shall be bound thereby, ***anything in the constitution or laws of any state to the contrary notwithstanding***." U.S. Const. Art. VI, cl. 2 (emphasis added). This Court's duty to uphold the constitution and laws of ***both*** the United States and the State of Missouri mandates that, when the latter conflicts with the former, this Court must apply the supremacy clause and federal law will prevail.

But the supremacy clause assigns primacy solely to federal ***law***. It does not provide – or even suggest – that the terms of a contract between the federal government and a private insurance company can override Missouri law regarding what terms are (and are not) permitted in contracts covering Missouri employees and their families. Accordingly, to the extent Congress sought to give preemptive effect to the benefit repayment terms in GHP's contract – and there is no doubt that this is what 5 U.S.C. § 8902(m)(1) does – the supremacy clause does not authorize that effort.

Associate Justice Sotomayor, while a judge on the United States Court of Appeals for the Second Circuit, authored the *McVeigh* decision that was affirmed by the Supreme Court. There, then-Judge Sotomayor noted that, even though federal courts (like the majority opinion in this case) "generally decide FEHBA cases as if § 8902(m)(1) were a preemption provision like any other, the provision is in fact quite unusual, because it provides that certain types of *contract terms* will 'supersede and preempt' state

laws in a particular field." *McVeigh*, 396 F.3d at 143 (emphasis in original).

Despite the graciously judicial understatement in which she characterizes FEHBA as "unusual" in this regard, then-Judge Sotomayor explained that the plain language of FEHBA's preemption provision is unconstitutional:

> Normally, preemption clauses provide that federal *law* will preempt state law. A typical provision might provide for preemption, for example, by expressly stating that the statute's provisions preempt state law, or by prohibiting state law from interfering with a policy established in federal law. Regardless of a given provision's structure or wording, however, ***we generally take for granted that it is law, and not a mere contract term, that carries the preemptive force***.
>
> Though § 8902(m)(1)'s plain language differs from typical preemption provisions by unambiguously providing for preemption by contract, such ***a literal reading of the provision is highly problematic, and probably unconstitutional***, because only federal *law* may preempt state and local law. The constitutionality of federal preemption is, after all, grounded in the Supremacy Clause of the Constitution, which provides that "*the Laws of the United States* ... shall be the supreme Law of the Land ... any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. Art. VI, cl. 2. (emphasis added). ***There is no constitutional basis for making the terms of con-***

> ***tracts with private parties similarly "supreme" over state law.***
>
> ***Taken literally, therefore, FEHBA's preemption provision may fail to withstand constitutional scrutiny unless FEHBA-authorized contracts themselves are "Laws of the United States." They are not.*** "Law" connotes a policy imposed by the government, not a privately-negotiated contract. Under FEHBA, the government does not impose contract terms as it would impose a law. Rather, the OPM negotiates the contract terms privately with insurance providers, who are under no obligation to enter into the contracts in the first place. Empire's attempt to portray FEHBA contracts as "law" is unavailing.

Id. at 143-44 (citations omitted) (emphasis in the original, bold emphasis added).

The Second Circuit in *McVeigh* did not strike down § 8902(m)(1) as unconstitutional, however. Then-Judge Sotomayor explained that a "saving" construction might cure the statute's patent constitutional defects:

> Here, we can reasonably construe § 8902(m)(1) as requiring that, in cases involving the "terms of any contract under [FEHBA] which relate to the nature, provision, or extent of coverage or benefits," *federal law* "shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). This construction is as faithful as constitutionally

> possible to the provision's plain language and respects Congress's stated intent to maintain "uniformity" in FEHBA benefits and to "displace State or local law relating to health insurance or plans." ***The federal law preempting state law may be federal common law or the FEHBA statute provisions themselves, but it must be law—not contract terms.***

Id. at 144-45 (citations omitted) (emphasis in the original, bold emphasis added).

I agree with the analysis conducted by then-Judge Sotomayor and with her conclusion that there "is no constitutional basis for making the terms of contracts with private parties similarly 'supreme' over state law." *Id.* at 143. Accordingly, I would hold that Congress's attempt in § 8902(m)(1) to give GHP's contractual benefit repayment terms preemptive effect over Missouri's law prohibiting such terms is not a valid exercise of the power embodied in the supremacy clause and, as a result, the terms of GHP's contract no more "supersede and preempt" Missouri law than do the terms of any wholly private contract.

After respectful consideration, there is no basis for adopting the saving construction offered by then-Judge Sotomayor. First, as then-Judge Sotomayor later explained, both her analysis of the constitutional infirmities of § 8902(m)(1) and her proposed saving construction were not holdings. *Empire HealthChoice Assur., Inc. v. McVeigh*, 402 F.3d 107, 110 (2d Cir. 2005) (petition for rehearing denied). Second, even assuming that the proposed reading "saves" § 8902(m)(1), it is not a valid "construction" of that statute. Instead, it is a material rewrite that

creates a result not only different from that which Congress plainly intended but almost antithetical to it. Congress is well aware of federal common law and the types of statutory frameworks that have been used to justify it. Congress refused to take any of these approaches with § 8902(m)(1) but chose instead the apparently unprecedented path of attempting to assign preemptive force to the terms agreed upon by OPM and its contractual partners. Accordingly, it appears that Congress not only wanted to wrest power over federal employee health care benefits away from the states, but it also was unwilling to cede that power to the courts in the form of a "blank check" authorization to create federal common law.

The final reason to reject the saving construction offered in *McVeigh*, 396 F.3d at 144-45, is that the Supreme Court thoroughly and completely rejected any argument that § 8902(m)(1) implicitly authorizes federal courts to supplant state law with common law of their own making. *McVeigh*, 547 U.S. at 698-99. Then-Judge Sotomayor may have taken a different path than the Supreme Court, but she reached the same conclusion concerning federal common law despite her proposed savings construction of the statute. *McVeigh*, 396 F.3d at 150 (nothing in § 8902(m)(1) "manifest[s] an intent to supplant all state law with federal common law in cases involving FEHBA-authorized contract provisions").

IV. Conclusion

For the reasons set forth above, I disagree with the rationale employed by the majority opinion, but I concur in the majority opinion's conclusion that the

trial court's judgment must be vacated and the case remanded for further proceedings.[8]

Paul C. Wilson, Judge

[8] The trial court entered judgment for GHP (and its agent, ACS) solely on the basis of *Buatte*. That judgment is now vacated on the ground that § 8902(m)(1) does not apply or – as I would hold – it is not a valid exercise of preemption under the supremacy clause. However, neither the majority opinion nor this concurrence analyze whether the trial court's summary judgment should be affirmed on the alternative grounds raised by GHP in its motion. For example, even assuming that Nevils' consumer fraud claim states a claim for relief notwithstanding GHP's reliance on the express terms of its federal contract, on § 8902(m)(1), and on *Buatte*, such a claim may be barred by section 407.020(2), which exempts from chapter 407 all companies subject to licensure by the department of insurance. However, unless it is clear as a matter of law that none of the pleaded claims can state a claim against any defendant, the better course is to remand the case for further proceedings. *See Hoover v. Mercy Health*, 408 S.W.3d 140, 143 (Mo. banc 2013).

APPENDIX F

Supreme Court of the United States

No. **13-1305**

COVENTRY HEALTH CARE OF MISSOURI, INC., fka GROUP HEALTH PLAN, INC.,

Petitioner

v.

JODIE NEVILS

ON PETITION FOR WRIT OF CERTIORARI to the Supreme Court of Missouri.

THIS CAUSE having been submitted on the petition for writ of certiorari and the response thereto.

ON CONSIDERATION WHEREOF, it is ordered and adjudged by this Court that the petition for writ of certiorari is granted. The judgment of the above court in this cause is vacated with costs, and the cause is remanded to the Supreme Court of Missouri for further consideration in light of new regulations promulgated by the Office of Personnel Management (OPM). See OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29,203 (May 21, 2015) (5 C.F.R. 890.106).

IT IS FURTHER ORDERED that the petitioner Coventry Health Care of Missouri, Inc., fka Group Health Plan, Inc. recovers from Jodie Nevils Three Hundred Dollars ($300.00) for costs herein expended.

June 29, 2015

Clerk's costs: $300.00

A True copy SCOTT S. HARRIS

Test

Clerk of the Supreme Court of the United States

By: s/

APPENDIX G

U.S. Const. art. VI, cl. 2

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

5 U.S.C. § 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) an employee as defined by section 2105 of this title;

(B) a Member of Congress as defined by section 2106 of this title;

(C) a Congressional employee as defined by section 2107 of this title;

(D) the President;

(E) an individual first employed by the government of the District of Columbia before October 1, 1987;

(F) an individual employed by Gallaudet College;[1]

(G) an individual employed by a county committee established under section 590h(b) of title 16;

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[1] So in original. Does not conform to section catchline.

[1] See Change of Name note below.

(H) an individual appointed to a position on the office staff of a former President under section 1(b) of the Act of August 25, 1958 (72 Stat. 838);

(I) an individual appointed to a position on the office staff of a former President, or a former Vice President under section 4 of the Presidential Transition Act of 1963, as amended (78 Stat. 153), who immediately before the date of such appointment was an employee as defined under any other subparagraph of this paragraph; and

(J) an individual who is employed by the Roosevelt Campobello International Park Commission and is a citizen of the United States,

but does not include—

(i) an employee of a corporation supervised by the Farm Credit Administration if private interests elect or appoint a member of the board of directors;

(ii) an individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter on September 30, 1979, by reason of service in an Executive agency, the United States Postal Service, or the Smithsonian Institution in the area which was then known as the Canal Zone;

(iii) an employee of the Tennessee Valley Authority; or

(iv) an employee excluded by regulation of the Office of Personnel Management under section 8913(b) of this title;

(2) "Government" means the Government of the United States and the government of the District of Columbia;

(3) "annuitant" means—

(A) an employee who retires—

(i) on an immediate annuity under subchapter III of chapter 83 of this title, or another retirement system for employees of the Government, after 5 or more years of service;

(ii) under section 8412 or 8414 of this title;

(iii) for disability under subchapter III of chapter 83 of this title, chapter 84 of this title, or another retirement system for employees of the Government; or

(iv) on an immediate annuity under a retirement system established for employees described in section 2105(c), in the case of an individual who elected under section 8347(q)(2) or 8461(n)(2) to remain subject to such a system;

(B) a member of a family who receives an immediate annuity as the survivor of an employee (including a family member entitled to an amount under section 8442(b)(1)(A), whether or not such family member is entitled to an annuity under section 8442(b)(1)(B)) or of a retired employee described by subparagraph (A) of this paragraph;

(C) an employee who receives monthly compensation under subchapter I of chapter 81 of this title and who is determined by the Secretary of Labor to be unable to return to duty; and

(D) a member of a family who receives monthly compensation under subchapter I of chapter 81 of this title as the surviving beneficiary of—

(i) an employee who dies as a result of injury or illness compensable under that subchapter; or

(ii) a former employee who is separated after having completed 5 or more years of service and who dies while receiving monthly compensation under that subchapter and who has been held by the Secretary to have been unable to return to duty;

(4) "service", as used by paragraph (3) of this section, means service which is creditable under subchapter III of chapter 83 or chapter 84 of this title;

(5) "member of family" means the spouse of an employee or annuitant and an unmarried dependent child under 22 years of age, including—

(A) an adopted child or recognized natural child; and

(B) a stepchild or foster child but only if the child lives with the employee or annuitant in a regular parent-child relationship;

or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

(6) "health benefits plan" means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;

(8) "employee organization" means—

(A) an association or other organization of employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter and which, after December 31, 1978, and before January 1, 1980, applied to the Office for approval of a plan provided under section 8903(3) of this title; and

(B) an association or other organization which is national in scope, in which membership is open only to employees, annuitants, or former spouses, or any combination thereof, and which, during the 90-day period beginning on the date of enactment of section 8903a of this title, applied to the Office for approval of a plan provided under such section;

(9) "dependent", in the case of any child, means that the employee or annuitant involved is either living with or contributing to the support of such child, as determined in accordance with such regulations as the Office shall prescribe;

(10) "former spouse" means a former spouse of an employee, former employee, or annuitant—

(A) who has not remarried before age 55 after the marriage to the employee, former employee, or annuitant was dissolved,

(B) who was enrolled in an approved health benefits plan under this chapter as a family member at any time during the 18-month period before the date of the dissolution of the marriage to the employee, former employee, or annuitant, and

(C)(i) who is receiving any portion of an annuity under section 8345(j) or 8467 of this title or a survivor annuity under section 8341(h) or 8445 of this title (or benefits similar to either of the aforementioned annuity benefits under a retirement system for Government employees other than the Civil Service Retirement System or the Federal Employees' Retirement System),

(ii) as to whom a court order or decree referred to in section 8341(h), 8345(j), 8445, or 8467 of this title (or similar provision of law under any such retirement system other than the Civil Service Retirement System or the Federal Employees' Retirement System) has been issued, or for whom an election has been made under section 8339(j)(3) or 8417(b) of this title (or similar provision of law), or

(iii) who is otherwise entitled to an annuity or any portion of an annuity as a former spouse under a retirement system for Government employees,

except that such term shall not include any such unremarried former spouse of a former employee whose marriage was dissolved after the former em-

ployee's separation from the service (other than by retirement); and

(11) "qualified clinical social worker" means an individual—

(A) who is licensed or certified as a clinical social worker by the State in which such individual practices; or

(B) who, if such State does not provide for the licensing or certification of clinical social workers—

(i) is certified by a national professional organization offering certification of clinical social workers; or

(ii) meets equivalent requirements (as prescribed by the Office).

5 U.S.C. § 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 6101(b) to (d) of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(*l*) The Office shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1)[1] of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d)).

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

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[1] See References in Text note below.

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

(1) to implement hospitalization-cost-containment measures, such as measures—

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(*o*) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

5 U.S.C. § 8906. Contributions

(a)(1) Not later than October 1 of each year, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

(A) enrollments under this chapter for self alone;

(B) enrollments under this chapter for self plus one; and

(C) enrollments under this chapter for self and family.

(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

(3) For purposes of paragraph (2), the term "enrollee" means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

(b)(1) Except as provided in paragraphs (2), (3), and (4), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1)(A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.

(2) The biweekly Government contribution for an employee or annuitant enrolled in a plan under this chapter shall not exceed 75 percent of the subscription charge.

(3) In the case of an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title), the biweekly Government contribution shall be equal to the percentage which bears the same ratio to the percentage determined under this subsection (without regard to this paragraph) as the average number of hours of such employee's regularly scheduled workweek bears to the average number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time career basis (as determined under regulations prescribed by the Office).

(4) In the case of persons who are enrolled in a health benefits plan as part of the demonstration project under section 1108 of title 10, the Government contribution shall be subject to the limitation set forth in subsection (i) of that section.

(c) There shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) the annuity of each enrolled annuitant and there shall be contributed by the Government, amounts, in the same ratio as the contributions of the employee or annuitant and the Government under subsection (b) of this section, which are necessary for the administrative costs and the reserves provided for by section 8909(b) of this title.

(d) The amount necessary to pay the total charge for enrollment, after the Government contribution is deducted, shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) from the annuity of each enrolled annuitant. The withholding for an annuitant shall be the same as that for an employee enrolled in the same health benefits plan and level of benefits.

(e)(1)(A) An employee enrolled in a health benefits plan under this chapter who is placed in a leave without pay status may have his coverage and the coverage of members of his family continued under the plan for not to exceed 1 year under regulations prescribed by the Office.

(B) During each pay period in which an enrollment continues under subparagraph (A)—

(i) employee and Government contributions required by this section shall be paid on a current basis; and

(ii) if necessary, the head of the employing agency shall approve advance payment, recoverable in the same manner as under section 5524a(c), of a portion of basic pay sufficient to pay current employee contributions.

(C) Each agency shall establish procedures for accepting direct payments of employee contributions for the purposes of this paragraph.

(2) An employee who enters on approved leave without pay to serve as a full-time officer or employee of an organization composed primarily of employees as defined by section 8901 of this title, within 60 days after entering on that leave without pay, may file with his employing agency an election to continue his health benefits enrollment and arrange to pay currently into the Employees Health Benefits Fund, through his employing agency, both employee and agency contributions from the beginning of leave without pay. The employing agency shall forward the enrollment charges so paid to the Fund. If the employee does not so elect, his enrollment will continue during nonpay status and end as provided by

paragraph (1) of this subsection and implementing regulations.

(3)(A) An employing agency may pay both the employee and Government contributions, and any additional administrative expenses otherwise chargeable to the employee, with respect to health care coverage for an employee described in subparagraph (B) and the family of such employee.

(B) An employee referred to in subparagraph (A) is an employee who—

(i) is enrolled in a health benefits plan under this chapter;

(ii) is a member of a reserve component of the armed forces;

(iii) is called or ordered to active duty in support of a contingency operation (as defined in section 101(a)(13) of title 10);

(iv) is placed on leave without pay or separated from service to perform active duty; and

(v) serves on active duty for a period of more than 30 consecutive days.

(C) Notwithstanding the one-year limitation on coverage described in paragraph (1)(A), payment may be made under this paragraph for a period not to exceed 24 months.

(f) The Government contribution, and any additional payments under subsection (e)(3)(A), for health benefits for an employee shall be paid—

(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

(3) in the case of an employee of the legislative branch who is paid by the Chief Administrative Officer of the House of Representatives, from the applicable accounts of the House of Representatives; and

(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

(g)(1) Except as provided in paragraphs (2) and (3), the Government contributions authorized by this section for health benefits for an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

(2)(A) The Government contributions authorized by this section for health benefits for an individual who first becomes an annuitant by reason of retirement from employment with the United States Postal Service on or after July 1, 1971, or for a survivor of such an individual or of an individual who died on or after July 1, 1971, while employed by the United States Postal Service, shall through September 30, 2016, be paid by the United States Postal Service, and thereafter shall be paid first from the Postal Service Retiree Health Benefits Fund up to the amount contained in the Fund, with any remaining amount paid by the United States Postal Service.

(B) In determining any amount for which the Postal Service is liable under this paragraph, the amount of the liability shall be prorated to reflect only that por-

tion of total service which is attributable to civilian service performed (by the former postal employee or by the deceased individual referred to in subparagraph (A), as the case may be) after June 30, 1971, as estimated by the Office of Personnel Management.

(3) The Government contribution for persons enrolled in a health benefits plan as part of the demonstration project under section 1108 of title 10 shall be paid as provided in subsection (i) of that section.

(h) The Office shall provide for conversion of biweekly rates of contribution specified by this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

(i) An annuitant whose annuity is insufficient to cover the withholdings required for enrollment in a particular health benefits plan may enroll (or remain enrolled) in such plan, notwithstanding any other provision of this section, if the annuitant elects, under conditions prescribed by regulations of the Office, to pay currently into the Employees Health Benefits Fund, through the retirement system that administers the annuitant's health benefits enrollment, an amount equal to the withholdings that would otherwise be required under this section.

5 U.S.C. § 8907. Information to individuals eligible to enroll

(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after con-

sultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by sections 8903 and 8903a of this title.

(b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the—

(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

(2) procedure for obtaining benefits; and

(3) principal provisions of the plan affecting the enrollee and any eligible family members.

5 U.S.C. § 8909. Employees Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available—

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to

be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) A percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the Office to be reasonably adequate to provide a contingency reserve.

The Office, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of enrollees and the Government to, or to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

(d) When the assets, liabilities, and membership of employee organizations sponsoring or underwriting plans approved under section 8903(3) or 8903a of this title are merged, the assets (including contingency reserves) and liabilities of the plans sponsored or underwritten by the merged organizations shall be transferred at the beginning of the contract term next following the date of the merger to the plan sponsored or underwritten by the successor organization. Each employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title affected by a merger shall be transferred to the plan sponsored or underwritten by the successor organization unless he enrolls in another plan under this chapter. If the successor organization is an organization described in section 8901(8)(B) of this title, any employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title so transferred may not remain enrolled in the plan after the end of the contract term in which the merger occurs unless that individual is a full member of such organization (as determined under section 8903a(d) of this title).

(e)(1) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term fol-

lowing that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

(f)(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan administration subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(g) The fund described in subsection (a) is available to pay costs that the Office incurs for activities associated with implementation of the demonstration project under section 1108 of title 10.

5 U.S.C. § 8913. Regulations

(a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.

(b) The regulations of the Office may prescribe the time at which and the manner and conditions under which an employee is eligible to enroll in an approved health benefits plan described by section 8903 or 8903a of this title. The regulations may exclude an employee on the basis of the nature and type of his employment or conditions pertaining to it, such as short-term appointment, seasonal or intermittent employment, and employment of like nature. The Office may not exclude—

(1) an employee or group of employees solely on the basis of the hazardous nature of employment;

(2) a teacher in the employ of the Board of Education of the District of Columbia, whose pay is fixed by section 1501 of title 31, District of Columbia Code, on the basis of the fact that the teacher is serving under a temporary appointment if the teacher has been so employed by the Board for a period or periods totaling not less than two school years;

(3) an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title); or

(4) an employee who is employed on a temporary basis and is eligible under section 8906a(a).

(c) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefits plans. The regulations may permit the coverage to continue, exclusive of the temporary extension of coverage described by section 8902(g) of this title, until the end of the pay period in which an employee is separated from the service, or until the end of the month in which an annuitant or former spouse ceases to be entitled to annuity, and in case of the death of an employee or annuitant, may permit a temporary extension of the coverage of members of his family for not to exceed 90 days.

(d) The Secretary of Agriculture shall prescribe regulations to effect the application and operation of this chapter to an individual named by section 8901(1)(H) of this title.

5 U.S.C. § 8959. Preemption

The terms of any contract that relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to dental benefits, insurance, plans, or contracts.

5 U.S.C. § 8989. Preemption

The terms of any contract that relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to vision benefits, insurance, plans, or contracts.

5 U.S.C. § 9005. Preemption

(a) CONTRACTUAL PROVISIONS.—The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to long-term care insurance or contracts.

(b) PREMIUMS.—

(1) IN GENERAL.—No tax, fee, or other monetary payment may be imposed or collected, directly or indirectly, by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, on, or with respect to, any premium paid for an insurance policy under this chapter.

(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to exempt any company or other entity issuing a policy of insurance under this chapter from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such entity from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

9 U.S.C. § 2. Validity, irrevocability, and enforcement of agreements to arbitrate

A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

10 U.S.C. § 1103. Contracts for medical and dental care: State and local preemption

(a) OCCURRENCE OF PREEMPTION.—A law or regulation of a State or local government relating to health insurance, prepaid health plans, or other health care delivery or financing methods shall not apply to any contract entered into pursuant to this chapter by the Secretary of Defense or the administering Secretaries to the extent that the Secretary of Defense or the administering Secretaries determine that—

(1) the State or local law or regulation is inconsistent with a specific provision of the contract or a regulation promulgated by the Secretary of Defense or the administering Secretaries pursuant to this chapter; or

(2) the preemption of the State or local law or regulation is necessary to implement or administer the provisions of the contract or to achieve any other important Federal interest.

(b) EFFECT OF PREEMPTION.—In the case of the preemption under subsection (a) of a State or local law or regulation regarding financial solvency, the Secretary of Defense or the administering Secretaries shall require an independent audit of the prime contractor of each contract that is entered into pursuant to this chapter and covered by the preemption. The audit shall be performed by the Defense Contract Audit Agency.

(c) STATE DEFINED.—In this section, the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, and each possession of the United States.

12 U.S.C. § 85. Rate of interest on loans, discounts and purchases

Any association may take, receive, reserve, and charge on any loan or discount made, or upon any notes, bills of exchange, or other evidences of debt, interest at the rate allowed by the laws of the State, Territory, or District where the bank is located, or at a rate of 1 per centum in excess of the discount rate on ninety-day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and no more, except that where by the laws of any State a different rate is limited for banks organized under State laws, the rate so limited shall be allowed for associations organized or existing in any such State under title 62 of the Revised Statutes. When no rate is fixed by the laws of the State, or Territory, or District, the bank may take, receive, reserve, or charge a rate not exceeding 7 per centum,

or 1 per centum in excess of the discount rate on ninety day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and such interest may be taken in advance, reckoning the days for which the note, bill, or other evidence of debt has to run. The maximum amount of interest or discount to be charged at a branch of an association located outside of the States of the United States and the District of Columbia shall be at the rate allowed by the laws of the country, territory, dependency, province, dominion, insular possession, or other political subdivision where the branch is located. And the purchase, discount, or sale of a bona fide bill of exchange, payable at another place than the place of such purchase, discount, or sale, at not more than the current rate of exchange for sight drafts in addition to the interest, shall not be considered as taking or receiving a greater rate of interest.

21 U.S.C. § 360k. State and local requirements respecting devices

(a) General rule

Except as provided in subsection (b) of this section, no State or political subdivision of a State may establish or continue in effect with respect to a device intended for human use any requirement—

(1) which is different from, or in addition to, any requirement applicable under this chapter to the device, and

(2) which relates to the safety or effectiveness of the device or to any other matter included in a re-

quirement applicable to the device under this chapter.

(b) Exempt requirements

Upon application of a State or a political subdivision thereof, the Secretary may, by regulation promulgated after notice and opportunity for an oral hearing, exempt from subsection (a) of this section, under such conditions as may be prescribed in such regulation, a requirement of such State or political subdivision applicable to a device intended for human use if—

(1) the requirement is more stringent than a requirement under this chapter which would be applicable to the device if an exemption were not in effect under this subsection; or

(2) the requirement—

(A) is required by compelling local conditions, and

(B) compliance with the requirement would not cause the device to be in violation of any applicable requirement under this chapter.

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section

1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 through 393–51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to

be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary

determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Co-

lumbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(e) Automatic contribution arrangements

(1) Notwithstanding any other provision of this section, this subchapter shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement—

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 1104(c)(5) of this title.

(3)(A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which—

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and

before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

5 C.F.R. § 890.101. Definitions; time computations *(excerpts)*

* * *

Reimbursement means a carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection withthat illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

* * *

Subrogation means a carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

* * *

5 C.F.R. § 890.106. Carrier entitlement to pursue subrogation and reimbursement recoveries

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section.

(b)(1) Any FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(2) Any health benefits plan contract that contains a subrogation or reimbursement clause shall provide that benefits and benefit payments are extended to a covered individual on the condition that the FEHB carrier may pursue and receive subrogation and reimbursement recoveries pursuant to the contract.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability

insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of 5 CFR 890.101 and is therefore not subject to the disputed claims process set forth at 5 CFR 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of

coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

48 C.F.R. § 1602.170-2. Community rate

(a) *Community rate* means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan carrier. References in this subchapter to "a combination of cost and price analysis" relating to the applicability of policy and contract clauses refer to comprehensive medical plan carriers using community rates.

(b) *Adjusted community rate* means a community rate which has been adjusted for expected use of medical resources of the FEHBP group. An adjusted community rate is a prospective rate and cannot be retroactively revised to reflect actual experience, utilization, or costs of the FEHBP group, except as described in § 1615.402(c)(4).

48 C.F.R. § 1602.170-7. Experience-rate

Experience-rate means a rate for a given group that is the result of that group's actual paid claims, administrative expenses (including capitated administrative expenses), retentions, and estimated claims incurred but not reported, adjusted for benefit modifications, utilization trends, and economic trends. Actual paid claims include any actual or negotiated

benefits payments made to providers of services for the provision of healthcare such as capitation not adjusted for specific groups, including mental health benefits capitation rates, per diems, and DRG payments.

48 C.F.R. § 1632.170. Recurring premium payments to carriers

(a)(1) *Recurring payments to carriers of community-rated plans.* OPM will pay to carriers of community-rated plans the premium payments received for the plan less the amounts credited to the contingency and administrative reserves, amounts assessed under paragraph (a)(2) of this section, and amounts due for other contractual obligations. Premium payments will be due and payable not later than 30 days after receipt by the Federal Employees Health Benefits (FEHB) Fund.

(2) The difference between one percent and the performance based percentage of the contract price described at 1615.404–4 will be multiplied by the carrier's subscription income for the year of performance and the resulting amount (performance adjustment) will be withheld from the net-to-carrier premium disbursement during the first quarter of the following contract period unless an alternative payment arrangement is made with the carrier's Contracting Officer. Amounts withheld from a community rated plan's premium disbursement will be deposited into the plan's Contingency Reserve.

(3) Any subsidization penalty levied against a community rated plan as outlined in 48 CFR 1615.402(c)(3)(ii)(B) must be paid within 60 days from notification. If payment is not received within

the 60 day period, OPM will withhold from the community rated carriers the periodic premium payment payable until fully recovered. OPM will deposit the withheld funds in the subsidization penalty reserve described in 5 C.F.R. 890.503(c)(6).

(b)(1) *Recurring payments to carriers of experience-rated plans.* OPM will make payments on a letter of credit (LOC) basis. Premium payments received for the plan, less the amounts credited to the contingency and administrative reserves and amounts for other obligations due under the contract, will be made available for carrier drawdown not later than 30 days after receipt by the FEHB Fund.

(2) Withdrawals from the LOC account will be made on a checks-presented basis. Under a checks-presented basis, drawdown on the LOC is delayed until the checks issued for FEHB Program disbursements are presented to the carrier's bank for payment.

(3) OPM may grant a waiver of the restriction of LOC disbursements to a checks-presented basis if the carrier requests the waiver in writing and demonstrates to OPM's satisfaction that the checks-presented basis of LOC disbursements will result in significantly increased liability under the contract, or that the checks-presented basis of LOC disbursements is otherwise clearly and significantly detrimental to the operation of the plan. Payments to carriers that have been granted a waiver may be made by an alternative payment methodology, subject to OPM approval.

APPENDIX H

FEHB Program Carrier Letter

All Carriers

U.S. Office of Personnel Management

Federal Employee Insurance Operations

Letter No. 2012-18

Date: June 18, 2012

Fee-for-service [15] Experience-rated HMO [15] Community-rated HMO [17]

SUBJECT: FEHBA Preemption of State Law re: Subrogation and Reimbursement

The purpose of this letter is to address concerns raised about the ability of Federal Employees Health Benefits (FEHB) Program carriers to collect subrogation and/or reimbursement recoveries. These recoveries occur when an enrollee who is injured obtains benefits from his or her FEHB Program plan and either 1) the plan recovers payment for those benefits from a third party tortfeasor as a subrogee of the enrollee or 2) the enrollee pursues an action against a third party tortfeasor and the terms of the plan require the enrollee, as a result of recovery, to reimburse the plan for benefits initially paid.

Some states are not allowing FEHB Program carriers to collect subrogation and/or reimbursement recoveries due to state law that either prohibits or limits these recoveries. This is to advise you that the Federal Employees Health Benefits Act (FEHBA) preempts state laws prohibiting or limiting subrogation and reimbursement. As a result, FEHB Pro-

gram carriers are entitled to receive these recoveries regardless of state law.

The FEHBA, as codified at 5 U.S.C. § 8902(m)(1) provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

FEHB Program contracts and the applicable statement of benefits (brochures) require enrollees to reimburse the plan in the event of a third party recovery. Carriers are required to seek reimbursement and/or subrogation recoveries in accordance with the contract. The funds received by experience-rated carriers from these recoveries are required to be credited to Employees Health Benefits Fund established by 5 U.S.C. § 8909, held by the Treasury of the United States, and for experience-rated carriers and most community-rated carriers, subrogation and reimbursement recoveries serve to lower subscription charges for individuals enrolled in the Federal Employees Health Benefits Program. The carrier's right to subrogation and /or reimbursement recovery is both a condition of, and a limitation on, the payments that enrollees are eligible to receive for benefits; the carrier's contractual obligation to obtain them necessarily relates to the enrollee's coverage or benefits (including payments with respect to benefits) under the FEHB Program. These recoveries therefore fall within the purview of the FEHBA's preemption clause, and supersede state laws that relate to health insurance or health plans.

The United States Supreme Court provided, in *Empire Healthchoice Assurance, Inc. v. McVeigh* that it is plausible to construe subrogation and reimbursement contract terms as a condition or limitation on benefits received by a Federal employee, allowing these FEHB Program contract requirements to preempt state law according to 5 U.S.C. § 8902(m)(1). See, 547 U.S. 677, 697-698 (2006). OPM maintains this construction of the statute allowing for preemption of state laws relating to subrogation and reimbursement.

In support of OPM's position, Federal courts have held that state laws restricting or prohibiting subrogation and/or reimbursement activities "relate" to plans for purposes of triggering the state law preemption provisions of FEHBA. See, e.g.. *Medcenters Health Care v. Ochs*, 26 F.3d 865 (8th Cir. 1994); *NALC Health Benefit Plan v. Lunsford*, 879 F. Supp. 760 (E.D. Mich. 1995); *Botsford v Blue Cross and Blue Shield of Montana, Inc.* 314 F.3d 390 (9th Cir. 2002)(as to conflict preemption).

As the Federal agency with regulatory authority over the FEHB Program, OPM has consistently recognized that the FEHBA preempts state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts, and we continue to maintain this position.

Please utilize this correspondence as needed in your recovery efforts.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

APPENDIX I

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT FOR COMMUNITY-RATED HEALTH MAINTENANCE ORGANIZATION CARRIERS

2006

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1930 AMENDMENT NO: 2006
EFFECTIVE: January 1, 2006 EFFECTIVE: January 1, 2006

BETWEEN: The United States Office of Personnel Management
hereinafter called OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3640

AND

CONTRACTOR: GROUP HEALTH PLAN, INC.
hereinafter called the Carrier

Address: 111 CORPORATE OFFICE DRIVE, SUITE 400
EARTH CITY, MO 63045

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
Frank D'Antonio	WILLIAM T. STUART
Name of person authorized to execute contract *type or print)*	Name of Contracting Officer *type or print)*
Vice President, Sales & Marketing	CONTRACTING OFFICER
Title	Title
s/	s/
Signature	Signature
11/2/05	November 18, 2005
Date signed	Date signed

* * *

PART I – GENERAL PROVISIONS

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SECTION 1.4
INCORPORATION OF LAWS AND REGULATIONS (JAN 2002)

(a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890, title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the Contracting Officer will make an equitable adjustment in accordance with the changes clause, Section 5.38 – Changes—Negotiated Benefits Contracts.

* * *

SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL
(JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of non-renewal is given either by OPM or the Carrier not less than 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. § 8902(e). After OPM notifies the Carrier of its intent to terminate the contract, OPM may take action as it deems necessary to protect the interests of Members, including but not limited to--

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies; and

(3) Providing Enrollees an opportunity to transfer to another plan.

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

* * *

PART II – BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1999)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) The Carrier shall, subject to the approval of the Contracting Officer, define an area from which it will accept enrollments. The Carrier may limit enrollment to individuals residing or employed inside the approved area.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any claim forms as necessary.

SECTION 2.2
BENEFITS PROVIDED (JAN 1999)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier, after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each case when the Carrier provides a benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. Such payment or provision of

services or supplies shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide for a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2003)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request; *provided*, however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.11 *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) When members are required to file claims for covered benefits, benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish

satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for receiving benefits and filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition. The examinations shall be made at the expense of the Carrier.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) When claim filing is required, benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and, when claim filing is required, may reimburse that person for any period covered medical service or supply.

(3) Reimbursement Payments to family members covered under Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and when

claim filing is required, the Carrier may reimburse that person for any covered medical service or supply.

(4) Compliance with the HIPAA Privacy Rule. The Carrier may pay benefits to a covered person other than the Enrollee when in the exercise of its discretion the Carrier decides that such action is necessary to comply with the HIPAA Privacy Rule, 45 C.F.R. §164.500 et seq.

(5) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(4) shall fully discharge the Carrier to the extent of such payment.

(g) *Erroneous Payments.* If the Carrier of OPM determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence

and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases to a collection attorney or a collection agency if the debt is not recovered;

(5) Make a prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue future collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(7) Maintain records that document individual unrecovered erroneous payment collection activities for audit or future reference.

SECTION 2.4
TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after

termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C, chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5
SUBROGATION (JAN 1998)

(a) The Carrier shall subrogate FEHB claims in the same manner in which it subrogates claims for

non-FEHB members, according to the following rules:

(1) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is permitted, and in which the Carrier subrogates for non-FEHB members;

(2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA);

(3) The Carrier shall not subrogate if it is doing business in a State that prohibits subrogation, and in which the Carrier does not subrogate for any plan covered under ERISA;

(4) For Carriers doing business in more than one State, the Carrier shall apply the rules in (1) through (3) of this subsection according to the rule applicable to the State in which the subrogation would take place.

(b) The Carrier's subrogation procedures and policies shall be shown in the agreed upon brochure text or made available to the enrollees upon request.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 2001)
(FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefit coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC *Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits*, as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC *Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits*, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term. *[NOTE: Subsection 2.6(b) will not be applied to this community-rated carrier. When there is double coverage for covered benefits, other than emergency services from non-Plan providers, the Health Maintenance Organization Carrier will con-*

tinue to provide benefits in full, but will seek payment for the services and supplies provided, to the extent that the services and supplies are covered by the other coverage, no-fault automobile insurance or other primary plan. Likewise, Subsection 2.6(d) is not applicable to community-rated carriers.]

SECTION 2.7
DEBARMENT AND OTHER SANCTIONS (JAN 1999)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 CFR 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995) (FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim, (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered

individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to the other individuals or entities who are acting on behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the phone bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual

or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial request, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this

clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulation, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or services was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9
PROTECTION OF MEMBERS AGAINST PROVIDER CLAIMS (JAN 1996)

(a) The Carrier shall provide the Contracting Officer with evidence that its contracts with providers (hospitals and physicians) contain a provision that, in the event of Carrier insolvency, or inability to pay expenses for any reason, the providers shall not look to Members for payment. The Carrier agrees that over 90 percent of the total benefit cost under this contract will be provided under such contracts with providers; or

(b) In lieu of subsection (a) above, the Contracting Officer may accept such other combinations of coverage which provide protection of Members against provider claims as defined in the NAIC (National Association of Insurance Commissioners) Model HMO Act, as amended; or

(c) The Carrier shall provide the Contracting Officer with documentation that it has such other appropriate combinations of coverage which would provide protection of Members against provider claims in the event of Carrier insolvency, or inability to pay expenses for any reason.

(d) The Carrier shall notify the Contracting Officer as soon as it is aware that it will not be able to satisfy the requirements stated in subsections (a), (b), or (c) above.

SECTION 2.10
INDEPENDENT LABORATORIES (JAN 1991)

In order to assure a minimum standard of quality for laboratory services, the Carrier agrees that it will not use independent laboratories which do not comply with Medicare or similar standards.

SECTION 2.11
CLAIMS PROCESSING (JAN 2001)

A standardized claims filing process shall be used by all FEHB carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) The majority of provider claims should be submitted electronically;

(2) All providers shall be notified that future claims must be submitted electronically, or on the Centers for Medicare and Medicaid Services 1500 form or the UB-92 form;

(3) The Carrier shall not use any unique provider claim form(s) for FEHB member claims;

(4) The Carrier shall reject all claims submitted on forms other than the CMS 1500 form or the UB-92 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.12
CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligations for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons.

SECTION 2.13
BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 2006)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for a coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A and Appendix D of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, copayments, and the balance between the Medicare approved amount

and the Medicare limiting charge made by non-participating providers.

SECTION 2.14
CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER (JAN 2004)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that continue after termination. The order of precedence for the applicable laws, regulations, and the contract are listed in Section 1.3.

(b) Contract requirements extend beyond the date of the Carrier's termination until the effective date of the new enrollment including processing and paying claims incurred prior to the effective date of the new enrollment.

(c) When the prior carrier is discontinued in whole or in part, the gaining carrier assumes full coverage on the effective date of the new enrollment.

SECTION 2.15
COORDINATION OF PRESCRIPTION DRUG BENEFITS WITH MEDICARE (JAN 2006)

(a) The Carrier shall comply with the Center for Medicare and Medicaid Services' (CMS) Part D Coordination of Benefits Guidance when the mechanisms and systems indicated in this guidance are in place and functioning properly. This guidance provides the requirements and procedures for coordination of benefits between Part D plans and other providers of prescription drug coverage.

(b) For Medicare Part B covered prescription drugs, the Carrier will coordinate benefits with Medicare except when such prescription drugs are purchased from retail or mail order pharmacies. The

Carrier may pay its benefit on retail pharmacy or mail order drugs eligible for Medicare Part B coverage.

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PART V – REQUIRED CLAUSES

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SECTION 5.50
FEHBP TERMINATION FOR DEFAULT—NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-72)

(a)(1) The Government may, subject to paragraphs (c) and (d) below, by written notice of default to the Carrier, terminate this contract in whole or in part if the Carrier fails to—

(i) Perform the services within the time specified in this contract or any extension;

(ii) Make progress, so as to endanger performance of this contract (but see subparagraph (a)(2) below); or

(iii) Perform any of the other provisions of this contract (but see subparagraph (a)(2) below).

(2) The Government's right to terminate this contract under subdivisions (1)(ii) and (1)(iii) above, may be exercised if the Carrier does not cure such failure within 10 days (or more if authorized in writing by the Contracting Officer) after receipt of the notice from the Contracting Officer specifying the failure.

(b) If the Government terminates this contract in whole or in part, it may acquire, under the terms and in the manner the Contracting Officer considers appropriate, supplies or service similar to those terminated, and the Carrier will be liable to the Govern-

ment for any excess costs for those supplies or services. However, the Carrier shall continue to work not terminated.

(c) Except for defaults of subcontractors at any tier, the Carrier shall not be liable for any excess costs if the failure to perform the contract arises from causes beyond the control and without the fault or negligence of the Carrier. Examples of such causes include (1) acts of God or of the public enemy, (2) acts of the Government in either its sovereign or contractual capacity, (3) fires, (4) floods, (5) epidemics, (6) quarantine restrictions, (7) strikes, (8) freight embargoes, and (9) unusually severe weather. In each instance the failure to perform must be beyond the control and without the fault or negligence of the Carrier.

(d) If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both the Carrier and subcontractor, and without the fault or negligence of either, the Carrier shall not be liable for any excess costs for failure to perform, unless the subcontracted supplies or services were obtainable from other sources in sufficient time for the Carrier to meet the required delivery schedule.

(e) If this contract is terminated for default, the Government may require the Carrier to transfer title and deliver to the Government, as directed by the Contracting Officer, any completed or partially completed information and contract rights that the Carrier has specifically produced or acquired for the terminated portion of this contract.

(f) If, after termination, it is determined that the Carrier was not in default, or that the default was

excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the Government.

(g) The rights and remedies of the Government in this clause are in addition to any other rights and remedies provided by law or under this contract.

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SECTION 5.62
APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004) (FAR 52.233-4)

United States law will apply to resolve any claim of breach of this contract.

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APPENDIX J

Group Health Plan
http://www.ghp.com

GHP **2006**
A Coventry Health Care Plan

A Health Maintenance Organization and a High Deductible Health Plan

Serving: St. Louis/Metro East area, Central Missouri, and Central and Southern Illinois

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.

* * *

The disputed claims process *(continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM

decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-755-3901 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

* * *

When others are responsible for injuries

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

* * *

APPENDIX K

Federal Register / Vol. 80, No. 4 / Wednesday, January 7, 2015 / Proposed Rules

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206–AN14

Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery

AGENCY: Office of Personnel Management.

ACTION: Proposed rule.

SUMMARY: The United States Office of Personnel Management (OPM) is issuing a proposed rule to amend the Federal Employees Health Benefits (FEHB) Program regulations to clarify the conditional nature of FEHB Program benefits and benefit payments under the plan's coverage as subject to a carrier's entitlement to subrogation and reimbursement recovery, and therefore, that such entitlement falls within the preemptive scope of the U.S.C. FEHB contracts must include a provision incorporating the carrier's subrogation and reimbursement rights and FEHB plan brochures must explain the carrier's subrogation and reimbursement policy.

DATES: Comments are due on or before February 6, 2015.

ADDRESSES: Send written comments to Marguerite Martel, Senior Policy Analyst, Planning and Policy Analysis, U.S. Office of Personnel Management, Room 4312, 1900 E Street NW., Washington, DC; or

FAX to (202) 606-4640 Attn: Marguerite Martel. You may also submit comments using the *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.

FOR FURTHER INFORMATION CONTACT: Marguerite Martel at *Marguerite.Martel@opm.gov* or (202) 606-0004.

SUPPLEMENTARY INFORMATION: The FEHB Act, as codified at 5 U.S.C. 8902(m)(1) provides: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." This proposed regulation reaffirms that a covered individual's entitlement to FEHB benefits and benefit payments is conditioned upon, and limited by, a carrier's entitlement to subrogation and reimbursement recoveries pursuant to a subrogation or reimbursement clause in the FEHB contract. This proposed regulation also reaffirms that a FEHB carrier's rights and responsibilities pertaining to subrogation and reimbursement relate to the nature, provision and extent of coverage or benefits and benefit payments provided under title 5, United States Code Chapter 89, and therefore are effective notwithstanding any state or local law or regulation relating to health insurance or plans. This interpretation comports with longstanding Federal policy, lowers the cost of benefits, and creates greater uniformity in benefits and benefits administration.

Currently, and consistent with longstanding practice, FEHB Program contracts and the applic[illegible]ble statement of benefits (brochures) generally re

quire carriers to seek reimbursement and/or subrogation recoveries, and covered individuals to reimburse the plan in the event of a third party recovery, in accordance with the terms of their FEHB contracts. The funds received by experience-rated carriers from these recoveries are required to be credited to the Employees Health Benefits Fund established by 5 U.S.C. 8909, held by the Treasury of the United States. For experience-rated carriers and most community-rated carriers, subrogation and reimbursement recoveries serve to lower subscription charges for individuals enrolled in the Federal Employees Health Benefits Program. These recoveries occur when an enrollee who is injured obtains benefits from his or her FEHB Program plan and either (1) the carrier recovers payment for those benefits from a third party as a subrogee of the enrollee or (2) the enrollee recovers payment for those benefits from a third party and the terms of the plan require the enrollee, as a result of recovery, to reimburse the carrier for benefits initially paid.

As OPM explained in carrier letter 2012–18 (June 18, 2012), and as this proposed regulation would reaffirm, the carrier's right to subrogation and/or reimbursement recovery is a condition of the payments that enrollees are eligible to receive for benefits, and a limitation on their entitlement to the provision of these benefits. Subrogation and reimbursement clauses in turn relate to the nature, provision, and extent of coverage or benefits (and the payment of benefits) by making those payments conditional upon a right to subrogation or reimbursement of equivalent amounts, either from a third-party, or from the enrollee, in the event a third party is obligated to pay for the same injury or illness. The carrier's right to pursue these recoveries therefore

falls within the purview of 5 U.S.C. 8902(m)(1), and supersedes state laws that relate to health insurance or health plans.

Interpreting subrogation and reimbursement clauses to fall within Section 8902(m)(1) is consistent with the definition of subrogation and reimbursement described above and their relationship to benefits and the payment of benefits. This interpretation also furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts. The FEHB program insures approximately 8.2 million federal employees, annuitants, and their families, a significant proportion of whom are covered through nationwide fee-for-service plans with uniform rates. The government pays on average approximately 70% of Federal employees' plan premiums. 5 U.S.C. 8906(b), (f). The government's share of FEHB premiums in 2014 was approximately $33 billion, a figure that tends to increase each year. OPM estimates that FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries in that year. Subrogation recoveries translate to premium cost savings for the federal government and FEHB enrollees. These cost savings are consistent with Congress's intent as expressed in the legislative history of the 1998 amendment to 5 U.S.C. 8902(m)(1), indicating that Congress intended 5 U.S.C. 8902(m)(1) to "prevent carriers' cost-cutting initiatives from being frustrated by State laws," H. Rept. No. 105–374 at 9, 105th Cong., 1st Sess. (1997), and with uniform administration and cost-savings principles first envisioned as major goals of Congress as it initially enacted the FEHBA in 1959. See, H.R. Rep No. 86–957, 86th Cong. 1st Sess. (1959).

In addition to its cost-savings goals, OPM recognizes a strong federal interest in national uniformity in coverage and benefits to include uniform administration of the FEHB program across state lines. This principle encompasses the need to apply uniform rules that affect the rights and obligations of enrollees in a given plan without regard to where they live. Disuniform application of FEHB contract terms as they apply to enrollees in different states is administratively burdensome, gives rise to uncertainty and litigation, and results in treating enrollees differently, although enrolled in the same plan and paying the same premium. It is OPM's understanding that Congress enacted the preemption provision to avoid such disparities, and to enhance the ability of the Federal Government to offer its employees a program of health benefits governed by a uniform set of legal rules.

This proposed rule also clarifies that where a covered individual challenges a carrier's right of subrogation and reimbursement, that challenge is not a "claim," which current OPM regulations define as "a request for payment of a health-related bill" or the "provision of a health-related service or supply." 5 CFR 890.101. Because subrogation and reimbursement challenges are not claims, they are not subject to the disputed claims process set forth at 5 CFR 890.105, 890.107.

The proposed rule adds definitions of subrogation and reimbursement to 5 CFR 890.101. In addition, the regulation replaces the current section 890.106, which is no longer needed due to creation of the Civilian Board of Contract Appeals. The proposed section 890.106 defines an FEHB carrier's right to subrogation and reimbursement in accordance with this

part. As the Federal agency with regulatory authority over the FEHB Program, OPM has consistently taken the position that the FEHB Act preempts state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts, and we continue to maintain this position.

OPM is issuing proposed rule-making that further clarifies this provision of law.

Regulatory Impact Analysis

OPM has examined the impact of this proposed rule as required by Executive Order 12866 and Executive Order 13563, which directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public, health, and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for major rules with economically significant effects of $100 million or more in any one year. This rule is not considered a major rule because there will be a minimal impact on costs to Federal agencies.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation only affects health insurance benefits of Federal employees and annuitants. Executive Order 12866.

Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Orders 13563 and 12866.

Federalism

We have examined this rule in accordance with Executive Order 13132, Federalism, and have determined that this rule restates existing rights, roles and responsibilities of State, local, or tribal governments.

List of Subjects in 5 CFR Part 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance, Health professions, Hostages, Iraq, Kuwait, Lebanon, Military personnel, Reporting and recordkeeping requirements, Retirement.

U.S. Office of Personnel Management.
Katherine Archuleta,
Director.

Accordingly, OPM proposes to amend title 5, Code of Federal Regulations, part 890 as follows:

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

■ 1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913; Sec. 890.301 also issued under sec. 311 of Pub. L. 111–03, 123 Stat. 64; Sec. 890.111 also issued under section 1622(b) of Pub. L. 104–106, 110 Stat. 521; Sec. 890.112 also issued under section 1 of Pub. L. 110–279, 122 Stat. 2604; 5 U.S.C. 8913; Sec. 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; subpart L also issued under sec. 599C of Pub. L. 101–513, 104 Stat. 2064, as amended; Sec. 890.102 also issued under sections 11202(f), 11232(e), 11246 (b) and (c) of Pub. L. 105–33, 111 Stat. 251; and section

721 of Pub. L. 105–261, 112 Stat. 2061; Pub. L. 111–148, as amended by Pub. L. 111–152.

■ 2. In § 890.101(a), add definitions for "Reimbursement" and "Subrogation" in alphabetical order to read as follows:

§ 890.101 Definitions; time computations.

(a) * * *

Reimbursement means a carrier's pursuit of a recovery if a covered individual has been injured and has received a payment from a responsible third party and the terms of the plan require the covered individual, as a result of recovery, to pay the carrier out of the recovery to the extent of the benefits initially paid or provided.

* * * * *

Subrogation means a carrier's pursuit of a recovery from a responsible third party as successor to the rights of an injured covered individual who has obtained benefits from that health benefits plan.

* * * * *

■ 3. Section 890.106 is revised to read as follows:

§ 890.106 Carrier entitlement to pursue subrogation and reimbursement recoveries.

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section.

(b) In any health benefits plan that contains a subrogation or reimbursement clause, including con-

tracts entered into before the effective date of this regulation, benefits and benefit payments are extended to a covered individual on the condition that the FEHB carrier may pursue and receive subrogation and reimbursement recoveries if such benefits or benefit payments are for an injury or illness that is the responsibility of a third party. FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of § 890.101 and is therefore not subject to the disputed claims process set forth at § 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from the covered individual all amounts received by or on behalf of the covered individual by judgment, settlement, or other recovery from any third party or its insurer, or the covered individual's insurer, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under a FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

[FR Doc. 2014–30638 Filed 1–6–15; 8:45 am]

BILLING CODE 6325–63–P

APPENDIX L

Federal Register / Vol. 80, No. 98 / Thursday, May 21, 2015 / Rules and Regulations

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206–AN14

Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery

AGENCY: Office of Personnel Management.

ACTION: Final rule.

SUMMARY: The United States Office of Personnel Management (OPM) is issuing a final rule to amend the Federal Employees Health Benefits (FEHB) Program regulations to reaffirm the conditional nature of FEHB Program benefits and benefit payments under the plan's coverage as subject to a carrier's entitlement to subrogation and reimbursement recovery, and therefore, that such entitlement falls within the preemptive scope of the FEHA Act. FEHB contracts and brochures must include, and in practice already include, a provision incorporating the carrier's subrogation and reimbursement rights, and FEHB plan brochures must contain an explanation of the carrier's subrogation and reimbursement policy.

DATES: This final rule is effective June 22, 2015.

FOR FURTHER INFORMATION CONTACT: Marguerite Martel, Senior Policy Analyst at (202) 606-0004.

SUPPLEMENTARY INFORMATION: The FEHB Act, as codified at 5 U.S.C. 8902(m)(1), provides:

"The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." This final regulation reaffirms that a covered individual's entitlement to FEHB benefits and benefit payments is conditioned upon, and limited by, a carrier's entitlement to subrogation and reimbursement recoveries pursuant to a subrogation or reimbursement clause in the FEHB contract. This final regulation also reaffirms that a FEHB carrier's rights and responsibilities pertaining to subrogation and reimbursement relate to the nature, provision and extent of coverage or benefits and benefit payments provided under title 5, United States Code Chapter 89, and therefore are effective notwithstanding any state or local law or regulation relating to health insurance or plans. Some state courts have interpreted ambiguity in Section 8902(m)(1) to reach a contrary result and thereby to allow state laws to prevent or limit subrogation or reimbursement rights under FEHB contracts. In this final rule, OPM is exercising its rulemaking authority under 5 U.S.C. 8913 to ensure that carriers enjoy the full subrogation and reimbursement rights provided for under their contracts.

The interpretation of Section 8902(m)(1) promulgated herein comports with longstanding Federal policy and furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts. The FEHB program insures approximately 8.2 million federal employees, annuitants, and their families, a significant proportion of whom are covered through nationwide fee-for-service plans with uniform rates. The government

pays on average approximately 70% of Federal employees' plan premiums. 5 U.S.C. 8906(b), (f). The government's share of FEHB premiums in 2014 was approximately $33 billion, a figure that tends to increase each year. OPM estimates that FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries in that year. Subrogation recoveries translate to premium cost savings for the federal government and FEHB enrollees.

OPM proposed this amendment in a notice of proposed rulemaking on January 7, 2015 (80 FR 931). The proposed rule had a 30 day comment period during which OPM received 3 comments.

Responses to comments on the proposed rule:

OPM received comments from an association of FEHB carriers, a trade association serving subrogation and recovery professionals, and a provider of subrogation and recovery services. The comments all expressed support for the regulation and suggested some changes to clarify the language in the proposed rule.

All commenters suggested edits to the proposed definitions of "subrogation" and "reimbursement" at 5 CFR 890.101 to more completely reflect the universe of FEHB Program plan recoveries. All three commenters expressed concern with the reference to "a responsible third party" in the definitions, indicating that the use of this phrase has been interpreted to foreclose "first party" claims for subrogation and recoveries, such as uninsured and underinsured motorist coverage, and recommended adding other insurance including workers' compensation insurance, to the definition to be consistent with entitlements listed in the proposed § 890.106(c)(2) and (f). OPM

agrees that the definitions of subrogation and reimbursement should include first party claims. In addition, commenters noted that § 890.106(b) and (f) should be updated to reflect this change. The definitions at § 890.101 and other corresponding sections have been updated accordingly as necessary.

The commenters also suggested additional specific changes to the proposed definition of "reimbursement." Two of the commenters noted that the definition of reimbursement should address the situation of both illness and injury. OPM has revised the definition of reimbursement to accept this change. One commenter suggested that the final rule clarify that the right of reimbursement is cumulative with and not exclusive of the right of subrogation. OPM has incorporated this clarification. Two commenters suggested that the definition should reflect that a covered individual need not have actually received a recovery payment so long as the covered individual is entitled to receive a payment. OPM does not agree that the right of reimbursement is sufficiently broad to require an individual to reimburse the carrier in a circumstance where the individual has not actually received a recovery, and rejects this change. One commenter indicated that the right of reimbursement is specific to a recovery from an individual who has received a third party payment while the right of subrogation permits a carrier to recover directly from other sources. OPM agrees with this comment and has clarified the definition of "subrogation" accordingly.

One commenter suggested that § 890.106(b) be amended to align the regulation and FEHB carrier contract requirements. OPM has revised this section to refer to contractual requirements.

One commenter noted that § 890.106(f) should be clarified to ensure that the carrier has a subrogation right to recover directly from a responsible insurer all amounts available to or on behalf of the covered individual. We have clarified the provision accordingly.

Two commenters noted that proposed § 890.106(b) and (h) did not clearly reflect OPM's intention for this regulation to apply to existing contracts. We agree and are slightly revising the language of paragraphs (b) and (h) to be clearer. Paragraph (h) formalizes OPM's longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978. This interpretation applies to all FEHBA contracts. Paragraph (b)(1) in the final rule likewise formalizes OPM's longstanding interpretation of subrogation and reimbursement clauses in carrier contracts as constituting a condition of and a limitation on the nature of benefits or benefits payments and on the provision of benefit payments. See Carrier Letter 2012–18. FEHBA contracts that contain subrogation and reimbursement clauses condition benefits and benefit payments on giving the carrier a right to pursue subrogation and reimbursement and therefore are directly related to benefits, benefit payments, and coverage within the meaning of Section 8902(m)(1). The interpretations in paragraphs (b)(1) and (h) together clarify and ensure that carriers enjoy full subrogation and reimbursement rights notwithstanding any state law to the contrary, and they apply in any pending or future case.

To clarify further the relationship among subrogation, reimbursement, benefits, and coverage, we are also in paragraph (b)(2) requiring carrier con-

tracts that contain subrogation and reimbursement clauses to contain language specifying that benefits and benefit payments are extended to a covered individual on the condition that the carrier may pursue and receive subrogation and reimbursement. This substantive requirement, unlike the interpretation discussed above, will govern any benefit payment made under any carrier contract entered into after this regulation goes into effect.

OPM is issuing this final rule with changes to §§ 890.101(a) and 890.106(b) and (f) as described above.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation because the regulation only affects health insurance benefits of Federal employees and annuitants. Executive Order 12866.

Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Orders 13563 and 12866.

Federalism

We have examined this rule in accordance with Executive Order 13132, Federalism, and have determined that this rule restates existing rights, roles and responsibilities of State, local, or tribal governments.

List of Subjects in 5 CFR Parts 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance,

Health professions, Hostages, Iraq, Kuwait, Lebanon, Military personnel, Reporting and recordkeeping requirements, Retirement.

U.S. Office of Personnel Management.
Katherine Archuleta,
Director.

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

■ 1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913. Sec. 890.301 also issued under sec. 311 of Pub. L. 111–03, 123 Stat. 64; Sec. 890.111 also issued under section 1622(b) of Pub. L. 104–106, 110 Stat. 521; Sec. 890.112 also issued under section 1 of Pub. L. 110–279, 122 Stat. 2604; 5 U.S.C. 8913; Sec. 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; subpart L also issued under sec. 599C of Pub. L. 101–513, 104 Stat. 2064, as amended; Sec. 890.102 also issued under sections 11202(f), 11232(e), 11246 (b) and (c) of Pub. L. 105–33, 111 Stat. 251; and section 721 of Pub. L. 105–261, 112 Stat. 2061.

■ 2. In § 890.101, in paragraph (a), add definitions in alphabetical order for "reimbursement" and "subrogation" to read as follows:

§ 890.101 Definitions; time computations.

(a) * * *

Reimbursement means a carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and

the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

* * * * *

Subrogation means a carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

* * * * *

■ 3. Section 890.106 is revised to read as follows:

§ 890.106 Carrier entitlement to pursue subrogation and reimbursement recoveries.

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section.

(b)(1) Any FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(2) Any health benefits plan contract that contains a subrogation or reimbursement clause shall provide that benefits and benefit payments are extended to a covered individual on the condition that

the FEHB carrier may pursue and receive subrogation and reimbursement recoveries pursuant to the contract.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of 5 CFR 890.101 and is therefore not subject to the disputed claims process set forth at 5 CFR 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or

a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

[FR Doc. 2015–12378 Filed 5–20–15; 8:45 am]

BILLING CODE 6325–63–P

APPENDIX M

IN THE SUPREME COURT OF MISSOURI
No. SC93134

JODIE NEVILS,
Appellant,

v.

GROUP HEALTH PLAN, INC et al.
Respondents.

TRANSFER FROM THE MISSOURI COURT OF APPEALS EASTERN DISTRICT

AMICUS CURIAE BRIEF OF THE UNITED STATES IN SUPPORT OF RESPONDENTS

* * *

STATEMENT OF INTEREST

The United States respectfully submits this *amicus curiae* brief.

This case presents the question whether Missouri's anti-subrogation rule is preempted by the Federal Employee Health Benefits Act (FEHBA), which provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). The United States has a strong interest in the correct resolution of this issue, which concerns the health-insurance benefits that the federal government provides to federal employees pursuant to federal law.

STATEMENT

A. Statutory Background

1. Congress enacted the Federal Employees Health Benefits Act of 1959, Pub. L. No. 86-382, 73 Stat. 708, to establish a comprehensive program that would "assure maximum health benefits for [federal] employees at the lowest possible cost to themselves and to the Government." H.R. Rep. No. 86-957, at 4 (1959). Through FEHB plans, the federal government provides health insurance to millions of federal employees and their dependents.

The U.S. Office of Personnel Management administers the Federal Employees Health Benefits Act. The Act gives OPM authority to contract with insurance carriers to offer benefits to federal employees, annuitants, and dependents, 5 U.S.C. §§ 8902, 8903, 8903b, to seek civil penalties against FEHB insurance carriers who engage in misconduct in administering federal health plans, *id.* § 8902a(d), and to promulgate regulations implementing FEHBA, *id.* § 8913(a). Each contract must contain "a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable." *Id.* § 8902(d).

Federal employees have the option to enroll in FEHB plans under the terms of the contracts between OPM and insurance carriers. 5 U.S.C. § 8905(a). OPM must provide to federal employees the information necessary to make an informed choice among the various plans offered under FEHB, and OPM issues each enrolled employee a detailed statement setting forth the plan terms and proce-

dures for obtaining benefits under the plan. *Id.* § 8907.

The federal government shares responsibility with enrolled employees for paying the premiums under FEHB plans. 5 U.S.C. § 8906. The federal government pays on average approximately 70% of the employee's plan premium. *Id.* § 8906(b), (f). FEHB premiums are generally deposited into the Employee Health Benefits Fund in the U.S. Treasury. *Id.* § 8909(a).

Most FEHB program contracts provide for a right of subrogation. A right of subrogation requires, among other things, FEHB beneficiaries to reimburse the plan if the beneficiary recovers a tort judgment or settlement that compensated the insured, in whole or in part, for health-insurance benefits the plan paid. Carriers must seek reimbursement in accordance with the FEHB contract. The funds received from subrogation recoveries by experienced-rated carriers, such as fee-for-service carriers, are credited to the Employee Health Benefits Fund held by the Treasury. *See* 5 U.S.C. § 8909(a). Any surplus in the FEHB fund may be used, based on negotiations between OPM and the carrier, to reduce future government and employee contributions, increase plan benefits, or refund money to the government and plan enrollees. 5 U.S.C. § 8909(b); 5 C.F.R. § 890.503(c)(2). Subrogation recoveries credited to the FEHB fund thus translate to direct savings for the federal government and FEHB enrollees.

FEHB carriers also include community-rated carriers. Subrogation recoveries by community-rated carriers also lower subscription charges for enrollees and the federal government, but through a different

mechanism. The premiums that community-rated carriers charge generally depend on the expected cost of providing benefits. Subrogation recoveries by community-rated carriers tend to reduce those expected costs, and thus the premiums.

OPM has the ultimate authority to determine whether a claim for medical services should be paid under the FEHB program. 5 U.S.C. § 8902(j). If a carrier denies payment for a claim, the covered employee may seek OPM review. 5 C.F.R. § 890.105(a)(1). OPM's determination is subject to judicial review in federal court under the Administrative Procedure Act. 5 U.S.C. §§ 701, 706.

2. In the mid-1970s, Congress became concerned that various forms of state health insurance legislation affecting FEHB health insurance plans were resulting in "[i]ncreased premium costs to both the Government and enrollees," as well as "[a] lack of uniformity of benfits [sic] for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States." H.R. Rep. No. 94-1211, at 3 (1976). Many states had begun enacting laws "requiring not only specific types of care but the extent of benefits, family members to be covered, the age limits for family members, extension of coverage, the format and the type of informational material that must be furnished, including in some instances the type of language to be used ...." H.R. Rep. No. 95-282, at 6-7 (1977); *see* S. Rep. No. 95-903, at 7 (1978). Congress cured the emerging disuniformity by enacting a preemption provision providing that "[t]he provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with re-

spect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions." Act of Sept. 17, 1978, Pub. L. No. 95-368, 92 Stat. 606.

In 1998, Congress broadened the FEHBA preemption provision. *See* Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366. Congress, in particular, preempted not only laws regulating the nature and extent of benefits, but also those regulating the provision of coverage or benefits—such as laws that regulate nationwide managed-care organizations. *See* H.R. Rep. No. 105-374, at 9, 16 (1997). Congress also eliminated as a prerequisite to preemption that a state law be "inconsistent" with a FEHB contract, "thereby giving the federal contract provisions clear authority." S. Rep. No. 105-257, at 15 (1997). Congress did so to "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997).

As amended, the FEHBA's preemption provision provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

B. Factual Background

This case arises from an FEHB contract entered into between OPM and Group Health Plan Inc., a community-rated health plan. Section 2.5 of that contract provided that the carrier "shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members" under certain conditions, including where the carrier "is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974." Legal File (LF) 57. Although Missouri law generally prohibits insurance subrogation, *see, e.g.*, *Schweiss* v. *Sisters of Mercy, St. Louis, Inc.*, 950 S.W.2d 537, 538 (Mo. Ct. App. 1997), GHP subrogates FEHB claims in Missouri because it subrogates for at least one ERISA plan in Missouri, *see* LF 218.

Plaintiff Jodie Nevils is a former federal employee who was covered by a GHP-administered FEHB health-insurance plan while he was with the government. LF 292-93. In November 2006, plaintiff sustained injuries in a car crash. LF 292. The FEHB plan paid approximately $18,000 in benefits to defray plaintiff's medical bills. LF 293, 571. Plaintiff brought a tort suit against the driver and settled the case. LF 293. Pursuant to the FEHB plan's subrogation clause, GHP's agent, ACS Recovery Services Inc., asserted a lien against the settlement proceeds. LF 293, 573. ACS, GHP, and plaintiff settled the lien for $6,592.24. LF 575.

Plaintiff then brought this class-action suit in St. Louis County Circuit Court. The suit asserted multiple state-law causes of action against GHP, all of which were premised on the assertion that the ac-

tions of GHP and ACS in collecting $6,592.24 from plaintiff's tort settlement violated Missouri's anti-subrogation law. LF 294-300. Plaintiff sought unspecified damages and injunctive relief. LF 300.

GHP and ACS sought summary judgment, principally on the ground that the Federal Employees Health Benefits Act preempts Missouri's anti-subrogation law. LF 8-12, 349-62. The trial court agreed, explaining that the case was controlled by *Buatte* v. *Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. Ct. App. 1996), LF 864-65, which held that "Missouri state law prohibiting subrogation is preempted by the FEHBA." *Id.* at 442. The trial court found no basis for plaintiff's argument that more recent court decisions had deprived *Buatte* of its precedential effect, and no reason not to follow that controlling precedent. LF 865. The court therefore granted GHP and ACS summary judgment on all claims. *Id.*

The Missouri Court of Appeals affirmed, agreeing with the trial court that *Buatte* was controlling. 2012 WL 6689542, at *3 (Mo. Ct. App. Dec. 26, 2012). The court of appeals rejected plaintiff's arguments that *Buatte* should be reconsidered in light of subsequent legal developments. *Id.* at *3-*5. Plaintiff argued, specifically, that the Supreme Court's decision in *Empire Healthchoice Assurance* v. *McVeigh*, 547 U.S. 677 (2006), which also involved subrogation rights under a FEHB contract, controlled the preemption question presented here. The court of appeals explained, however, that "[t]he *Empire* court's holding was solely that federal question jurisdiction was lacking" over an action to enforce an insurance company's right to reimbursement for benefits paid under a FEHB contract. *Id.* at *5. The

court of appeals observed that this holding was "not even tangentially related" to the separate question of whether the FEHBA preempts Missouri's anti-subrogation rule. *Id.*

This Court granted plaintiff's motion to transfer.

POINTS RELIED ON

Response To Appellant's Point I: The Court Of Appeals Correctly Concluded That The Federal Employee Health Benefits Act Preempts Missouri's Anti-Subrogation Rule.

5 U.S.C. § 8902(m)(1)

FEHB Program Carrier Letter No. 2012-18 (June 18, 2012)

Buatte v. *Gencare Health Sys., Inc.*, 939 S.W.2d 440 (Mo. Ct. App. 1996)

MedCenters Health Care v. *Ochs*, 26 F.3d 865 (8th Cir. 1994)

NALC Health Benefit Plan v. *Lunsford*, 879 F. Supp. 760 (E.D. Mich. 1995)

ARGUMENT

The Federal Employee Health Benefits Act Preempts Missouri's Anti-Subrogation Rule.

A. Section § 8902(m)(1) Unambiguously Preempts Missouri's Anti-Subrogation Rule.

Like most health-insurance contracts, FEHB contracts generally provide for a right of subrogation. A subrogation right, among other things, permits the FEHB plan to receive reimbursement for any benefits paid under the plan to the extent that the enrollee has separately received a tort recovery that also

compensates for the very same expenses paid by the plan. Subrogation rights, in other words, prevent enrollees from receiving double reimbursement for their medical expenses. The vast majority of state jurisdictions permit subrogation if provided for by the express terms of a health insurance contract. Missouri, however, is in the minority of jurisdictions that do not permit subrogation, even when a health-insurance contract provides for it. *See* Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 734-35 & n.56 (2005).

1. The question in this case is whether the FEHBA preempts Missouri's anti-subrogation rule. The FEHBA provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

The sweeping terms of this express preemption provision comfortably encompass anti-subrogation laws. FEHB contract terms that provide a right of subrogation directly "relate to the ... extent of coverage or benefits" or, at the very least, "payments with respect to benefits." 5 U.S.C. § 8902(m)(1). Subrogation rights relate to benefit payments because they require a beneficiary to return benefits to the extent the beneficiary has been separately reimbursed for those benefits from a tort recovery. As the Missouri Court of Appeals observed in holding that the FEHBA preempts Missouri's anti-subrogation rule, "prohibiting" the carrier "from seeking reimbursement from its insured would clearly differ the extent

of coverage or benefits." *Buatte* v. *Gencare Health Sys., Inc.*, 939 S.W.2d 440, 442 (Mo. Ct. App. 1996); *accord MedCenters Health Care* v. *Ochs*, 26 F.3d 865, 867 (8th Cir. 1994) (holding Minnesota anti-subrogation law preempted by § 8902(m)(1)); *NALC Health Benefit Plan* v. *Lunsford*, 879 F. Supp. 760, 762-63 (E.D. Mich. 1995) (holding that § 8902(m)(1) preempted Michigan law to the extent Michigan law prohibited subrogation).

In this case, there is no dispute that the subrogation right in Section 2.5 of the GHP contract establishes that plaintiff is not entitled to FEHB benefits to the extent that plaintiff's medical bills were separately reimbursed out of a tort recovery or settlement. If plaintiff's state-law suit based on Missouri's anti-subrogation rule succeeds in defeating that right, plaintiff will have been permitted to retain FEHB benefits that he is not entitled to keep under the terms of the FEHB contract. Missouri's anti-subrogation rule straightforwardly relates to the extent of coverage or benefits under an FEHB plan and is therefore preempted.

2. The conclusion that Missouri's anti-subrogation rule relates to benefits and coverage, as well as payments with respect to benefits, draws support from Supreme Court cases construing the term "relat[es] to" in a preemption provision to "express a broad pre-emptive purpose." *Morales* v. *TWA*, 504 U.S. 374, 383 (1992). The Supreme Court has, with regard to the similarly worded preemption clause applicable to health-care plans regulated by the Employee Retirement Income Security Act of 1974, held that state anti-subrogation laws "relate to" such plans. *See FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-59 (1990); *see also Botsford* v. *Blue Cross* &

Blue Shield of Montana, Inc., 314 F.3d 390, 394 (9th Cir. 2002) (applying ERISA case law to interpreting 5 U.S.C. § 8902(m)(1)). In reaching that conclusion, the Supreme Court observed that anti-subrogation laws are related to the provision of benefits in that they "require[] plan providers to calculate benefit levels ... based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation," thus "frustrat[ing] plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *FMC Corp.*, 498 U.S. at 60. ERISA regulates the benefit plans that private employers offer their employees, while the FEHBA governs the health-benefit plans that the federal government provides. It is exceedingly unlikely that Congress intended a broader role for state law in the case of federal employees than in the case of private employees, or that Congress desired less uniformity in the case of federal employees.

3. The history and purpose of the FEHBA preemption provision confirms that Congress intended it to supersede state anti-subrogation law.

In the mid-1970s, states began undermining the uniformity of the FEHB program by mandating that insurance companies provide health-insurance benefits that were not covered under the terms of FEHB contracts. *See, e.g.*, H.R. Rep. No. 95-282, at 6 (1977). Congress became concerned that those laws resulted in FEHB enrollees in some states paying for benefits that they were not receiving, since some benefits were only provided in states that had mandated-benefit laws. *See* H.R. Rep. No. 94-1211, at 3 (1976). Congress also expressed concern that state mandated-benefit laws were increasing the cost of the FEHB program to the federal government, *see*

id., which pays the lion's share of FEHB premiums. In response to those developments, Congress broadly preempted state laws related to benefits or coverage that were inconsistent with FEHB contract terms, and later broadened preemption to supersede even state laws that were not expressly inconsistent with FEHB contracts. *See* Pub. L. No. 95-368, 92 Stat. 606 (1978); Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (1998).

Missouri's anti-subrogation rule is indistinguishable from the state mandated-benefit laws that Congress expressly targeted with the enactment of the FEHBA preemption provision. By permitting an FEHB enrollee to retain benefits that have been separately reimbursed by a tort recovery, Missouri law effectively requires FEHB providers to provide Missouri consumers with FEHB benefits that consumers in other states do not receive under the terms of the same FEHB contract. Most FEHB enrollees receive benefits under nationwide plans with uniform rates. If Missouri's anti-subrogation rule survives preemption, then, the loser will be FEHB enrollees in states that permit subrogation, who will be subsidizing the more generous benefits that Missouri law effectively mandates that FEHB carriers provide to Missouri residents. That kind of cross-subsidization creates precisely the disuniformity that Congress intended to preclude when it enacted the preemption provision, which it intended to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997).

Missouri's anti-subrogation rule also runs contrary to another key aim of Congress in providing for preemption, which was to "prevent carriers' cost-

cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997). Although not all FEHB contracts necessarily provide for a right of subrogation, the vast majority do. Any subrogation recoveries obtained by the carrier tend to reduce the premiums charged both to individuals enrolled in the FEHB program and to the federal government, which pays the bulk of FEHB premiums. The federal government's share of those premiums amounted to approximately $31.5 billion in 2012 alone.

Even if plaintiff were correct that subrogation does not relate to benefits within the meaning of § 8902(m)(1), then, Missouri's law would still be in conflict with the FEHBA because it would "stand[] as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Arizona* v. *United States*, 132 S. Ct. 2492, 2505 (2012) (internal quotation marks and citation omitted); *see id.* at 2501.

B. The Supreme Court's Decision In *McVeigh* Did Not Hold Otherwise.

In contending that state laws prohibiting subrogation survive the FEHBA's preemption provision, plaintiff makes virtually no attempt to grapple with the statute's language, purpose, or history. Instead, plaintiff spends the bulk of his brief arguing that the Supreme Court in *Empire Healthchoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006), has already decided the preemption question presented in this case in his favor. Pl. Br. 12-19. That contention is without merit.

1. The question presented in *McVeigh* was whether there is federal jurisdiction over a suit

brought by a FEHB health-insurance carrier to recover reimbursement that a beneficiary allegedly owed the FEHB program under an FEHB contract. 547 U.S. at 683. The Supreme Court held that there is no federal-question jurisdiction over such a suit, emphasizing that "Congress has not expressly created a federal right of action enabling insurance carriers ... to sue health-care beneficiaries in federal court to enforce reimbursement rights under contracts contemplated by FEHBA." *Id.* at 693.

In the course of resolving the jurisdictional issue, the Court explored the meaning of the preemption provision. "Reading the reimbursement clause" in the FEHB contract "as a condition or limitation on 'benefits' received by a federal employee," the Court explained, "the clause could be ranked among '[contract] terms ... relat[ing] to ... coverage or benefits' and 'payments with respect to benefits,' thus falling within § 8902(m)(1)'s compass." *Id.* at 697 (alterations the Supreme Court's). "On the other hand," the Court continued, "a claim for reimbursement ordinarily arises long after 'coverage' and 'benefits' questions have been resolved, and corresponding 'payments with respect to benefits' have been made to care providers or the insured." *Ibid.* "With that consideration in view, § 8902(m)(1)'s words may be read to refer to contract terms relating to the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received, and not to terms relating to the carrier's postpayments right to reimbursement." *Ibid.* (Court's emphasis). The Court, however, explained that it "need not choose between those plausible constructions" of the preemption clause "[t]o decide this case." *Id.* at 698.

Contrary to plaintiff's contention, the Supreme Court in *McVeigh* did not decide, and in fact expressly declined to decide, that state laws affecting a FEHB carrier's right to reimbursement do not relate to coverage or benefits under § 8902(m)(1). Although the Court did at one point "distinguish[] ... between benefits and reimbursement," *Blue Cross Blue Shield* v. *Cruz*, 495 F.3d 510, 513 (7th Cir. 2007), the Court also found it "plausible" to construe a carrier's right to reimbursement for benefits as directly relating to benefits, or at least "payments with respect to benefits." *McVeigh*, 547 U.S. at 698; *see id.* at 697; *see also Cruz*, 495 F.3d at 514 (deciding that federal jurisdiction did not exist over a carrier's reimbursement suit, but declining to decide whether state law was preempted under § 8902(m)(1)).

Plaintiff contends, based on the presumption against preemption of state law, that the Supreme Court's ambivalence about which of these interpretations is correct compels the conclusion that only one of them is correct—*viz.*, the interpretation disfavoring preemption. Pl. Br. 18-19. That argument is irreconcilable with the Supreme Court's conclusion that it is "plausible" to conclude that the FEHBA preempts state anti-subrogation laws, *McVeigh*, 547 U.S. at 698, which the Court would not have done if, as plaintiff asserts, the presumption against preemption made that interpretation implausible and impermissible. *McVeigh* therefore in no way diminishes the conclusion that the broad, sweeping language of the FEHBA preemption provision encompasses state anti-subrogation laws.

2. In any event, the Supreme Court's tentative attempt in *McVeigh*—in at best nonbinding *dictum*—to distinguish "benefits" from "reimbursement" is

simply untenable, particularly in the context of anti-subrogation laws such as the one before the Court in this case. Even putting to one side the evident oddity of viewing a right to reimbursement of benefits as being unrelated to benefits, a right of subrogation is not limited to "reimbursement," and may indeed directly concern "the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received." *McVeigh*, 547 U.S. at 697 (emphasis the Supreme Court's). If a beneficiary, for example, received a tort judgment that compensates for medical bills covered under the plan before receiving FEHB benefits from the carrier, a subrogation right would permit the carrier to deny the enrollee benefits before the plan ever paid them. Denying benefit payments clearly "relates to benefits." But the only difference between that scenario and the facts of this case is that here, the carrier paid plaintiff FEHB benefits before he obtained his tort settlement (or at least before the carrier or its recovery agent was aware of it). That distinction should make no difference: a subrogation right does not become unrelated to benefits simply because the benefits happen to have already been paid, and the carrier must seek reimbursement of improperly retained benefits after the fact from a tort judgment or settlement. Plaintiff's submission, by contrast, rests on the implausible presumption that Congress intended preemption of subrogation laws to depend on the timing of a tort judgment or settlement.

3. Since the Supreme Court decided *McVeigh*, the U.S. Office of Personnel Management, the agency Congress entrusted with administering the FEHBA, *see Dyer* v. *Blue Cross & Blue Shield Ass'n, Inc.*, 848 F.2d 201, 205 (D.C. Cir. 1988); *Blue Cross & Blue Shield* v. *Dep't of Banking & Finance*, 791 F.2d

1501, 1506 (11th Cir. 1986), has in an opinion letter construed 5 U.S.C. § 8902(m)(1) to preempt state anti-subrogation laws, adopting the interpretation of the preemption provision that the Supreme Court explicitly characterized as plausible in *McVeigh*. *See* FEHB Program Carrier Letter No. 2012-18 (June 18, 2012), Add. A1. OPM's letter confirms that a right of subrogation "is both a condition of, and a limitation on, the payments that enrollees are eligible to receive for benefits," and therefore preempts state laws that defeat subrogation rights. *Ibid.* OPM's letter also explains the strong federal interest in preemption of state anti-subrogation laws, which tend to increase the expense of the FEHB program. *Ibid.*

Although OPM's opinion letter lacks the force of law that typically accompanies a regulation promulgated after notice-and-comment rulemaking, OPM's authoritative construction of the FEHBA is nonetheless entitled to substantial weight.[1] *See Christensen* v. *Harris County*, 529 U.S. 576, 587 (2000) (citing *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 140 (1944)); *see also Dyer*, 848 F.2d at 205; *Blue Cross & Blue Shield*, 791 F.2d at 1506 (OPM's construction of § 8902(m)(1) entitled to deference as long as it is "reasonable"). OPM's plausible interpretation should be granted deference, *see Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 980-82 (2005), and confirms that Missouri's anti-subrogation rule is preempted.

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[1] Plaintiff's substitute brief asserts that OPM's opinion letter is "factually inaccurate and misleading" in stating that "Carriers are required to seek reimbursement and/or subrogation in accordance with the contract." Pl. Br. 23 (internal quotation marks omitted). But that statement is accurate because OPM's point is simply that, if an FEHB contract requires subrogation, the carrier should seek subrogation as the contract provides.

CONCLUSION

The judgment of the trial court should be affirmed.

* * *

MAY 2013

* * *

APPENDIX N

IN THE SUPREME COURT OF MISSOURI

JODIE NEVILS,	)	
	)	
Appellant,	)	
	)	
v.	)	Case No. SC93134
	)	
GROUP HEALTH PLAN, INC. ET AL.,	)	
	)	
	)	
Respondents	)	

UNOPPOSED MOTION OF THE UNITED STATES FOR LEAVE TO PARTICIPATE IN ORAL ARGUMENT

The Court has scheduled oral argument in this case for September 12, 2013. The United States respectfully requests leave to participate in the oral argument. Respondents' counsel have agreed to the United States' participation in argument and to cede 5 of their 15 minutes of argument time to the United States. Plaintiff does not oppose this motion.

The United States filed an *amicus curiae* brief in this case, which presents the question whether Missouri's anti-subrogation rule is preempted by the Federal Employee Health Benefits Act (FEHBA). The preemption provision states that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any

regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

The United States has a strong interest in the correct resolution of this issue, which concerns the health insurance benefits that the federal government provides to federal employees pursuant to federal law. The U.S. Office of Personnel Management is the agency Congress has entrusted with authority to administer the FEHBA. Courts have deferred to OPM's interpretation of the FEHBA, *see Dyer* v. *Blue Cross & Blue Shield Ass'n, Inc.*, 848 F.2d 201, 205 (D.C. Cir. 1988); *Blue Cross & Blue Shield* v. *Dep't of Banking & Finance*, 791 F.2d 1501, 1506 (11th Cir. 1986), and OPM respectfully submits that this Court would benefit from OPM's views on the proper scope of preemption. Under FEHBA, moreover, OPM contracts with insurance carriers to provide health insurance to federal employees, and the federal government is responsible for the lion's share of the premiums, paying approximately $31.5 billion in premiums on behalf of federal enrollees in 2012 alone. The federal government has a substantial interest in ensuring that FEHB insurance carriers may pursue subrogation recoveries, which tend to reduce the premiums the federal government and FEHBA enrollees pay under the FEHB program on a nationwide basis.

Henry C. Whitaker, an attorney with the Appellate Staff of the Civil Division of the U.S. Department of Justice, was the attorney principally responsible for preparing the *amicus* brief filed by the United States and would be the attorney assigned to present oral argument if the Court grants this motion. If the Court grants this motion, we would separately

submit a motion for Mr. Whitaker to be admitted to this Court's bar *pro hac vice*.

As noted, respondents' counsel have agreed to cede 5 of their 15 minutes of their oral argument time to the United States, and to the United States' participation in the argument. We have also consulted with counsel for plaintiff, and plaintiff does not oppose this motion.

* * *

Dated: July 22, 2013

APPENDIX O

IN THE SUPREME COURT OF MISSOURI

No. SC93134

JODIE NEVILS,
Appellant,

v.

COVENTRY HEALTH CARE OF MISSOURI, INC.
formerly known as Group Health Plan, Inc.,
Respondent.

On Remand from the Supreme Court
of the United States
No. 13-1305

Appeal from the Circuit Court of St. Louis County
No. 11SL-CC00535
Hon. Thea A. Sherry, Circuit Judge
(Transfer from No. ED98538)

AMICUS CURIAE BRIEF OF THE UNITED STATES IN SUPPORT OF RESPONDENT

* * *

INTRODUCTION

The United States respectfully submits this *amicus curiae* brief in support of respondent.

Under the Federal Employee Health Benefits Act (FEHBA), the federal government contracts with insurance carriers to provide health insurance to federal employees and their families, and pays tens of billions of dollars of the program's premiums. If a

FEHB contract term "relates[]" to "benefits" or "payments with respect to benefits," FEHBA preempts any state law that "relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). The question here is whether this statute preempts state laws that prevent FEHB carriers from enforcing contractual rights of subrogation and reimbursement.

This Court previously concluded that this statute does not preempt Missouri's anti-subrogation law. *See Nevils* v. *Group Health Plan, Inc.*, 418 S.W.3d 451, 460 (Mo. 2014) (Appellant's App. 6). The U.S. Supreme Court granted certiorari, vacated this Court's decision, and remanded for consideration of the issue in light of a new regulation issued by the Office of Personnel Management (OPM), which is the federal agency responsible for administering the FEHB program. *See* 135 S. Ct. 2886 (2015). The new OPM regulation concluded that subrogation and reimbursement provisions in FEHB contracts relate to benefits and benefit payments, and therefore under the statute are effective notwithstanding contrary state law. *See* 80 Fed. Reg. 29,203 (May 21, 2015) (Appellant's App. 17).

OPM's regulation is, as both this Court and the U.S. Supreme Court have recognized, a "plausible," *Nevils*, 418 S.W.3d at 545; *Empire Healthchoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677, 698 (2006), and hence reasonable, interpretation of the statute. The Tenth Circuit recently upheld the same OPM regulation that is at issue here. *See Helfrich* v. *Blue Cross & Blue Shield Ass'n*, __ F. 3d __, No. 14-3179, slip op. (10th Cir. Oct. 29, 2015). Accordingly, FEHBA preempts Missouri's anti-subrogation law, and the judgment of the court of appeals should be affirmed.

POINT RELIED ON

POINT 1: FEHBA Preempts Missouri's Anti-Subrogation Law.

Helfrich v. *Blue Cross & Blue Shield Ass'n*, __ F. 3d __, No. 14-3179, slip op. (10th Cir. Oct. 29, 2015)

City of Arlington v. *FCC*, 133 S. Ct. 1863, 1874 (2013)

Empire HealthChoice Assurance, Inc. v. *McVeigh*, 547 U.S. 677 (2006)

Smiley v. *Citibank (South Dakota), N.A.*, 517 U.S. 735 (1996)

OPM Final Rule, 80 Fed. Reg. 29,203 (May 21, 2005) (Appellant's App. 17)

5 C.F.R. § 890.106

ARGUMENT

POINT 1: FEHBA Preempts Missouri's Anti-Subrogation Law.

A. The Federal Employee Health Benefits Act provides: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

In *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006), the Supreme Court left open the question whether the terms in FEHB contracts providing for subrogation and reimbursement "relate to the ... extent of coverage or benefits"

or "payments with respect to benefits," 5 U.S.C. § 8902(m)(1), and thus preempt state anti-subrogation and reimbursement laws. On the one hand, the Supreme Court observed that "[r]eading the reimbursement clause" in a FEHB contract "as a condition or limitation on 'benefits' received by a federal employee," "the clause could be ranked among '[contract] terms ... relat[ing] to ... coverage or benefits' and 'payments with respect to benefits,' thus falling within § 8902(m)(1)'s compass." *McVeigh*, 547 U.S. at 697. "On the other hand," the Court continued, "a claim for reimbursement ordinarily arises long after 'coverage' and 'benefits' questions have been resolved, and corresponding 'payments with respect to benefits' have been made to care providers or the insured." *Id.* "With that consideration in view, § 8902(m)(1)'s words may be read to refer to contract terms relating to the beneficiary's entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received, and not to terms relating to the carrier's postpayments right to reimbursement." *Id.* (emphasis omitted). The Court concluded that it "need not choose between those plausible constructions" of the preemption clause "[t]o decide this case." *Id.* at 698.

OPM recently resolved through notice-and-comment rulemaking the question left open by *McVeigh*. The OPM regulation provides that "[a]ny FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage." 5 C.F.R. § 890.106(b)(1). Thus, "[a] carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and

extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1)." *Id.* § 890.106(h). "These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans." *Id.*[19]

The OPM regulation is a reasonable interpretation of the statute that Congress charged OPM with administering through rulemaking, *see* 5 U.S.C. § 8913(a), and the regulation is therefore controlling here, *see City of Arlington* v. *FCC,* 133 S. Ct. 1863, 1874 (2013). As this Court observed in its prior decision, *Nevils*, 418 S.W.3d at 454-55, the Supreme Court in *McVeigh* expressly acknowledged that it is "plausible" to regard FEHB contract terms providing for subrogation and reimbursement "as a condition or limitation on 'benefits' received by a federal employee." 547 U.S. at 697. It therefore left OPM free to interpret the statute to preempt state anti-subrogation and reimbursement laws. *See National Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 982 (2005). And as OPM explained, its interpretation "comports with longstanding Federal policy and furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." 80 Fed. Reg. at 29,203 (Appellant's App. 17). "The FEHB program insures approximately 8.2 million federal employees, annuitants, and their families, a significant propor-

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[19] OPM also created a prospective requirement that all FEHB contracts shall explicitly provide that benefits and benefit payments are conditioned on FEHB carriers' exercise of subrogation and reimbursement rights. *See* 80 Fed. Reg. at 29,204 (discussing 5 C.F.R. § 890.106(b)(2)) (Appellant's App. 18).

tion of whom are covered through nationwide fee-for-service plans with uniform rates." *Id.* "The government pays on average approximately 70% of Federal employees' plan premiums." *Id.* (citing 5 U.S.C. § 8906(b), (f)). "The government's share of FEHB premiums in 2014 was approximately $33 billion, a figure that tends to increase each year." *Id.* OPM estimated that "FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries in that year." *Id.* Accordingly, "[s]ubrogation recoveries translate to premium cost savings for the federal government and FEHB enrollees." *Id.*

The Tenth Circuit recently upheld the validity of this regulation in *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, __ F. 3d __, No. 14-3179, slip op. (10th Cir. Oct. 29, 2015). The court recognized that a right to reimbursement of FEHB benefits is "tied directly to 'payments with respect to benefits'" within the meaning of 5 U.S.C. § 8902(m)(1). *Helfrich*, slip op. at 31. The court correctly explained that "a carrier's contractual right to reimbursement and subrogation arises from its payment of benefits; and an enrollee's ultimate entitlement to benefit payments is conditioned upon providing reimbursement from any later recovery or permitting the Plan to recover on the enrollee's behalf." *Id.*

The court also concluded that OPM's regulation "strongly buttress[ed]" that conclusion. *Helfrich*, slip op. at 34. The court observed that OPM's views were entitled to weight because "[a]s the agency that has negotiated FEHBA contracts for federal employees for years, OPM has deep knowledge of the impact and interrelationships of contractual provisions." *Id.* at 38. "Its longstanding and persuasively explained view that subrogation and reimbursement provisions

are directly tied to employee health benefits and advance the congressional purposes served by § 8902(m)(1)," the court continued, "is, in our view, of sufficient weight to persuade us to agree with its conclusion regarding preemption." *Id.* at 38-39.[20]

B. Plaintiff provides no persuasive reason to disregard the OPM regulation and create a conflict with the Tenth Circuit.

1. Plaintiff argues that OPM's regulation is not entitled to deference under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council*, 467 U.S. 837 (1984), because OPM is interpreting the scope of an express preemption clause. Pl. Br. 39-44. The Tenth Circuit in *Helfrich* found it unnecessary to decide whether the OPM regulation was entitled to full *Chevron* deference, because it correctly upheld the validity of the agency's regulation even under the more demanding, less deferential standard of *Skidmore* v. *Swift*, 323 U.S. 134 (1944). *See Helfrich*, slip

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[20] Despite never advancing this argument at any stage in the prior Missouri court proceedings, plaintiff now contends that the contract contains no right to "reimbursement" because it only mentions "subrogation." Pl. Br. 20-25. The contract in this case provides that the carrier "shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members." Pl. Br. 9 n.2. It is OPM's understanding that, under this clause of the contract, the carrier was permitted to pursue both subrogation and reimbursement recoveries for FEHB members. While "subrogation" and "reimbursement" are indeed "separate legal and contractual rights," Pl. Br. 22 (citing OPM regulations), it is also true that the term "subrogation" is often in FEHB contracts used in a generic sense to encompass both a right of subrogation and a right of reimbursement, and that is the sense evidently meant here. *See New Orleans Assets, LLC* v. *Woodward*, 363 F.3d 372, 377 (5th Cir. 2004); *McVeigh*, 547 U.S. at 692 & n.4 (repeatedly observing that rights of subrogation and reimbursement are "linked").

op. at 37-38. Likewise, this Court may uphold the regulation without reaching the question of *Chevron* deference.

If this Court reaches the issue, *Chevron* deference is appropriate. As this Court previously explained, *Chevron* deference is "typically applied 'where an agency rule sets forth important rights and duties, where the agency focuses fully and directly on the issue, where the agency uses notice-and-comment procedures to promulgate a rule, [and] where the resulting rule falls within the statutory grant of authority." *Nevils*, 418 S.W.3d at 457 n.2 (quoting *Long Island Care at Home Ltd.* v. *Coke*, 551 U.S. 158, 173 (2007)). All of that is true of the regulation in question here. The Supreme Court has repeatedly applied the *Chevron* framework to an agency's construction of the preemptive scope of the statutes it administers, including express preemption clauses. *See Cuomo* v. *Clearing House Ass'n*, 557 U.S. 519, 525 (2009); *New York* v. *FERC*, 535 U.S. 1, 28 (2002); *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 496 (1996).

In *Smiley* v. *Citibank (South Dakota), N.A.*, 517 U.S. 735 (1996), for example, the Supreme Court was faced with the question whether a regulation of the Comptroller of the Currency interpreting Section 30 of the National Bank Act was valid. Section 30 was a preemption provision providing that a national bank may charge interest at the rate allowed by the laws of the State where the bank is located. *See id.* at 737. The Comptroller's regulation interpreted this provision to supersede state laws that prohibit a national bank from charging late-payment fees that are lawful in the bank's home state. *See id.* at 740. The Supreme Court deferred to the agency's interpreta-

tion and held that this regulation was entitled to *Chevron* deference because it was a "full-dress regulation, issued by the Comptroller himself and adopted pursuant to the notice-and-comment procedures of the Administrative Procedure Act." *Id.* at 741.

Even more recently, in *City of Arlington*, the Supreme Court rejected the contention that the applicability of *Chevron* deference depends on a provision-by-provision analysis of the statute an agency is charged with administering. 133 S. Ct. at 1868-73. The Court held that "the whole includes all of its parts," and rejected the claim that "a general conferral of rulemaking authority does not validate rules for *all* the matters the agency is charged with administering." *Id.* at 1874. The Court noted, for example, that it had "deferred to the FCC's assertion that its broad regulatory authority extends to pre-empting conflicting state rules." *Id.* at 1871. Here, the matters OPM is charged with administering likewise include FEHBA's preemption clause. *See* 5 U.S.C. §§ 8913(a), 8902(m)(1).

Nor is it surprising that Congress delegated OPM such authority. The statute provides for the preemption of state laws relating to health insurance or FEHB plans, where those state laws conflict with FEHB contract terms that relate to benefits or benefit payments. *See* 5 U.S.C. § 8902(m)(1). Congress, in turn, expressly delegated OPM authority to negotiate and interpret those contract terms in providing health benefits for the federal government's own employees. *See id.* § 8902(a); 5 C.F.R. § 890.105(a)(1). The preemption question here thus implicates issues at the core of OPM's specialized expertise over administration of the FEHB program. Deference to agency preemption determinations is especially ap-

propriate when the "agency is likely to have a thorough understanding of its own regulation and its objectives and is uniquely qualified to comprehend the likely impact of state requirements." *Geier* v. *American Honda Motor Co.*, 529 U.S. 861, 883 (2000) (internal quotation marks omitted).

FEHBA's legislative history confirms the point. As plaintiff repeatedly notes, OPM's predecessor entity, the Civil Service Commission, had expressed doubt, before the enactment of FEHBA's preemption clause in 1978, whether the Commission had statutory authority to issue a regulation regarding FEHBA preemption. Pl. Br. 39, 42 (citing Report of the Comptroller General of the U.S.: *Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employee Health Benefits Carriers* at 15 (Oct. 15 1975) (Appellant's App. 62)). What plaintiff does not note is that this doubt led the Civil Service Commission to urge Congress to enact the preemption clause at issue in this case "giv[ing] the Commission clear authority to issue regulations restricting the application of State laws when their provisions do not parallel the provisions in the Commission's health benefits contracts." S. Rep. No. 95-903, at 4 (1978) (Appellant's App. 32). In response, Congress enacted § 8902(m)(1) to "clarify the Federal Government's and the Civil Service Commission's authority to regulate implementation of the law." *Id.* It has thus been clear since the enactment of the preemption clause in 1978 that the agency has authority to issue regulations regarding the scope of FEHBA preemption.

2. In arguing the contrary, plaintiff declares that "an agency's formal statements ... are only entitled to deference if Congress has *explicitly* 'authorize[d]'

the agency 'to pre-empt state law directly.'" Pl. Br. 40 (quoting *Wyeth* v. *Levine*, 555 U.S. 555, 576 (2009)). But the Supreme Court has repeatedly rejected plaintiff's premise, Pl. Br. 41-42, that Congress is required to use particular magic words in order to make a delegation regarding preemption effective. *See, e.g.*, *City of Arlingon*, 133 S. Ct. at 1871; *Smiley*, 517 U.S. at 743-44. *Wyeth*, on which plaintiff heavily relies for that notion, certainly stands for no such proposition. *Wyeth* involved no notice-and-comment regulation, but rather a preamble that conflicted with the agency's traditional position on the matter. *Id.* at 576-77. The Court was careful to caution that it was not considering "the pre-emptive effect of a specific agency regulation bearing the force of law." *Id.* at 580.

Here, OPM has promulgated a formal regulation thorough notice and comment—which is within the heartland of agency action entitled to *Chevron* deference. *See City of Arlington*, 133 S. Ct. at 1868-73; *United States* v. *Mead*, 533 U.S. 218, 230 (2001). Congress, moreover, made FEHBA preemption turn on what FEHB contract terms require of FEHB beneficiaries, which OPM has express authority not only to negotiate and interpret, but also to promulgate rules regarding. *See* 5 U.S.C. § 8902(a); 8913(a); 5 C.F.R. § 890.105(a)(1); *see also Wyeth*, 555 U.S. at 576 (citing 21 U.S.C. § 360k as an example of an explicit delegation of preemption authority) *Medtronic*, 518 U.S. at 484 n.5, 496-97 & n.15 (upholding delegation of preemption authority to the FDA under § 360k because Congress made preemption turn on what on "requirements" promulgated by the agency conflicted with state law). The effect of state law on the welfare of FEHBA beneficiaries under the terms of FEHB contracts that OPM itself negotiated falls

squarely within OPM's specialized expertise, and it is clear that Congress delegated authority to the agency to speak to it through rulemaking.

Contrary to plaintiff's suggestions, Pl. Br. 44-54, OPM's rule reflects careful analysis of not only the underlying FEHB contracts, but also the text, purpose, and history of the FEHBA preemption provision. *See Helfrich*, slip op. at 34-35. As OPM, the Supreme Court, and this Court have all recognized, it is plausible to understand a condition or limitation on the receipt of benefit payments to be "related to" benefits and benefit payments on the face of the statute. 80 Fed. Reg. 931, 932 (Jan. 7, 2015); *McVeigh*, 547 U.S. at 697; *Nevils*, 418 S.W.3d at 545-55. And not even plaintiff questions OPM's further conclusion that state anti-subrogation laws, in turn, "relate to health insurance or plans" within the meaning of the statute and therefore are preempted. *See* 5 C.F.R. § 890.106(h).

FEHB contracts, moreover, concern the health benefits the federal government provides to its own employees. As OPM found, this interpretation of the preemption clause and the FEHB contract terms "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." 80 Fed. Reg. at 932 (citing FEHBA legislative history). OPM determined, in particular, that state anti-subrogation and reimbursement laws are unfair to FEHB beneficiaries because they make beneficiaries' entitlement to benefit payments, even under nationwide FEHB plans with uniform rates, depend on the accident of their state of residence. *See* 80 Fed. Reg. at 932. As the Tenth Circuit concluded, this "longstanding and persuasive-

ly explained view" is plainly entitled to deference. *Helfrich*, slip op. at 38-39.

3. Plaintiff argues that the OPM regulation contravenes the "presumption against preemption." Pl. Br. 44. The Tenth Circuit in *Helfrich*, however, correctly concluded that no such presumption applies to FEHBA. The court reasoned that "[t]he federalism concern (respecting state sovereignty) behind the presumption against preemption has little purchase in this case," given that FEHBA "governs only contracts for the benefit of federal employees." Slip op. at 30. Where contract terms relate to benefits, FEHBA expressly displaces conflicting state laws that, in turn, "relate[] to health insurance or plans." 5 U.S.C. § 8902(m)(1). "It is an understatement to say that there has been a history of significant federal presence in the area of federal employment." *Helfrich*, slip op. at 30 (internal quotation marks and citation omitted). The Court should not presume that Congress intended a patchwork of state laws to govern the provision of health insurance benefits to federal employees.

In any event, the Supreme Court has held that any presumption against preemption, even if otherwise applicable, cannot overcome an agency regulation adopting one of two plausible interpretations of an express preemption clause. The Court was faced with that question in *Smiley*. In analyzing whether the agency reasonably interpreted the statute to preempt state law, the Supreme Court refused to apply a presumption against preemption, and rejected the argument that such a presumption "trumps *Chevron*" where, as here, an agency is interpreting a statute that unquestionably is preemptive. *See Smiley*, 517 U.S. at 743. The agency's rule, in short, au-

thoritatively resolved any preexisting ambiguity in the statute. *See Brand X*, 545 U.S. at 980-86.

Plaintiff misreads the *Smiley* decision to leave open the question whether the presumption against preemption applies to an agency regulation construing an express preemption clause. Pl. Br. 47-48. But *Smiley* was clear that the presumption against preemption does not "trump[] *Chevron*" where, as is the case here, an agency promulgates a regulation construing the meaning of "a statute" that "is preemptive." 517 U.S. at 743-44. The question *Smiley* left open is whether that same rule applies to a regulation construing a statute that *does not* expressly preempt state law—an issue the Court noted was "*not* the question" before it because there was no doubt that the provision before it "pre-empt[ed] state law." *Id.* at 744; *see also id.* at 737 (discussing the preemption clause in Section 30 of the National Bank Act). The question left open in *Smiley* therefore has nothing to do with this case, which, as in *Smiley*, concerns the substantive meaning of a clause that is expressly preemptive.

4. Plaintiff also contends that OPM overlooked the constitutional-avoidance doctrine in interpreting FEHBA to preempt state anti-subrogation law. Pl. Br. 45-47.[21] But the OPM regulation does avoid any constitutional issue. It interprets § 8902(m)(1), a federal statute, to preempt state law in certain circumstances. *See* 5 C.F.R. § 890.106(h); *Empire*

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[21] Plaintiff's preferred interpretation, in any event, does not avoid the purported constitutional problem, because plaintiff apparently agrees that the statute preempts "state laws that would compel FEHB carriers to cover certain types of health benefits or comply with certain coverage-related issues." Pl. Br. 50.

Healthchoice Assurance, Inc. v. *McVeigh*, 396 F.3d 136, 144 (2d Cir. 2005) (Sotomayor, J.), *aff'd*, 547 U.S. 677 (2006). That is an eminently reasonable reading of the statute, which does not make contract terms themselves preemptive of state law, even where those terms may relate to benefits or benefit payments. Instead, preemption is triggered only if the relevant state law, in turn, "relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). It is therefore the statute itself that picks out which state laws are preempted. OPM's reading is a plausible interpretation of the preemption clause, and avoids the constitutional concerns expressed by Judge Wilson the last time this case was before this Court. *See Nevils*, 418 S.W.3d at 464-65 (Appellant's App. 11). Federal statutes routinely provide for preemption of state law based in part on the terms of contracts. *See, e.g.*, *Hillman* v. *Maretta*, 133 S. Ct. 1943, 1948-49 (2013) (involving 5 U.S.C. § 8709(d)(1)); 5 U.S.C. §§ 8959, 8989, 9005(a); 9 U.S.C. § 2; 10 U.S.C. § 1103(a); 29 U.S.C. § 1144(a). Statutes of this kind present no Supremacy Clause problem.

CONCLUSION

The judgment of the Circuit Court should be affirmed.

* * *

NOVEMBER 2015

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RECORD AND BRIEFS

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IN THE

Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,
Petitioner,

v.

JODIE NEVILS,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of Missouri

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QUESTIONS PRESENTED

1. Whether FEHBA's express-preemption provision, 5 U.S.C. § 8902(m)(1), preempts state laws that restrict carriers from seeking subrogation or reimbursement pursuant to their FEHBA contracts.

2. Whether FEHBA's express-preemption provision, 5 U.S.C. § 8902(m)(1), violates the Supremacy Clause.

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INTRODUCTION

Though centered on a preemption clause in a little-known federal statute, the Federal Employee Health Benefits Act (FEHBA), 5 U.S.C. § 8902(m)(1), this case implicates fundamental questions about federalism and an agency's power to expand its preemptive reach. Coventry Health Care argues that FEHBA preempts state laws prohibiting insurance carriers from bringing repayment or subrogation claims against tort victims. But FEHBA only preempts state laws that "relate to the nature, provision, or extent of coverage or benefits." *Id.* And, as both this Court and the Office of Personnel Management (OPM) have recognized, the text of FEHBA's preemption clause is ambiguous on the question whether it blocks state repayment and subrogation laws. *See Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 697 (2006); Br. of U.S. as Amicus Curiae at 18, *Nevils v. Group Health Plan*, 492 S.W.3d 918 (Mo. 2016) (addressing § 8902(m)(1)'s "preexisting ambiguity").

This is the second time this case has come before the Court. After the Missouri Supreme Court initially refused to allow FEHBA's ambiguous preemption clause to trample state law, Coventry petitioned for certiorari. Nevils opposed that petition, arguing then that the question of FEHBA's preemptive reach was undeveloped—as was any split. At the time, no other state high court or federal circuit had considered the issue in light of *McVeigh*—the "beacon" by which courts must "steer" in this arena. *Lopez-Munoz v. Triple-S Salud, Inc.*, 754 F.3d 1, 7 (1st Cir. 2014). Other factors also cut against review: the Solicitor General had yet to weigh in, and OPM had not yet injected itself into the fray by passing an unprecedented formal regulation designed to leverage textual ambiguity (and *Chevron* deference) to override a

court's interpretation of an express-preemption clause. There was also no reason to disturb the Missouri Supreme Court's opinion; it hewed closely to *McVeigh* and was grounded in sound principles of statutory construction.

Although the Missouri Supreme Court's decision remains sound, Nevils recognizes that other factors bearing on certiorari have changed. Since the last petition, three more appellate courts have confronted the preemption question and, based on a kaleidoscope of rationales, have concluded that state law must yield to provisions in private insurance contracts. *See Bell v. Blue Cross and Blue Shield of Okl.*, 823 F.3d 1198 (8th Cir. 2016); *Kobold v. Aetna Life Ins. Co.*, 370 P.3d 128 (Ariz. Ct. App. 2016) ("*Kobold II*"); *Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090 (10th Cir. 2015). Moreover, OPM's express-preemption rule has now become final, squarely implicating this Court's unsettled law over whether an agency may ever receive *Chevron* deference for its interpretation of the scope of an express-preemption clause.

As a result, Nevils concedes that the question presented is now certworthy. In particular, the divergence between the Missouri Supreme Court here and the Eighth Circuit in *Bell* creates an untenable conflict between state and federal courts in the same state. And opposing views from the Tenth Circuit and the Arizona Court of Appeals trigger substantially greater geographic uncertainty over FEHBA preemption. Given the conflicting decisions, Nevils recognizes that, even if Coventry's petition is denied here, these questions could be decided in another case and jeopardize any future recovery for Nevils and the putative class that he represents.

This case, moreover, is admittedly the best vehicle available for finally resolving the important matters im-

plicated by FEHBA's "puzzling" preemption clause, *McVeigh*, 547 U.S. at 680, and OPM's *Chevron*-driven gambit to squelch state law through bureaucratic fiat. Unlike any of the other cases, the Missouri Supreme Court here reached every possible issue. It held that § 8902(m)(1) does not preempt Missouri's anti-subrogation law as a matter of statutory construction and, in the alternative, ruled that § 8902(m)(1) unconstitutionally violates the Supremacy Clause. And it also rejected OPM's bid to turn *Chevron* deference into a tool for dismantling state law. This is the only live case presenting all three issues.

Accordingly, if the Court is inclined to grant certiorari to resolve the split over FEHBA preemption, Nevils acknowledges that this would be a superior vehicle. But make no mistake: The Missouri Supreme Court has twice gotten it right. In *McVeigh*, this Court deemed FEHBA's preemption clause "puzzling" and "unusual"—it is not only ambiguous but also "declares no federal law preemptive," instead purporting to vest private insurance contracts with the power to preempt state law. 547 U.S. at 697-98. For these reasons, the Court stressed that the clause "warrants cautious interpretation" and demands a "modest reading." *Id.* at 697-98. The Missouri Supreme Court did just that.

STATEMENT

1. In 1959, Congress enacted the Federal Employee Health Benefit Act (FEHBA), 5 U.S.C. § 8901 *et seq.*, to establish a program for administering health benefits to federal employees. From its inception, Congress intended the program to work alongside state law. In recognition that "[a]ll states regulate the health insurance business in various and varying ways," S. Rep. No. 95-903, at 7 (1978), Congress intentionally did "not design[]" the federal program "to regulate the insurance business or

override any State regulatory scheme." Report of the Comptroller General of the United States, B-164562, *Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers* 15 (1975) (hereinafter "Comptroller Report"). Instead, states continued to hold the "authority to both regulate and tax" those health insurance carriers who participated in the federal program. *Id.* Congress made sure that FEHB carriers well understood their state-law compliance obligations. In a 1970 conference report, it recommended that OPM—then known as the U.S. Civil Service Commission, or CSC—"take appropriate action to inform carriers that the fact that they are administering a Federal contract is no reason for circumventing compliance with applicable State laws." *Id.* at 16.

FEHBA's dual-regulatory design worked well. During the law's "early years," carriers had "few if any problems" complying with both federal and state requirements. S. Rep. No. 95-903, at 7. But in the mid-1970s some states began mandating health-insurance coverage for certain "kinds of benefits and medical practitioners"—"chiropractic[] services" or acupuncture, for instance—not typically covered by FEHB carriers. *See id.* at 2-4. These laws "presented serious problems" for FEHB carriers because they "placed carriers in serious jeopardy of loss of their license in a state unless they were to approve a payment" for a specific type of coverage "not provided under [a FEHB] contract but required by state law." *See id.* at 7.

To address this tension, the carriers urged CSC to act—insisting that the agency "issue a regulation restricting the applicability of State law to FEHB contracts." Comptroller Report at 15. The agency refused. First, it made clear that its "position has been that 'the States have the authority to both regulate and tax health

insurance carriers operating under [FEHBA].'" *Id.* It therefore told carriers that (1) "the FEHB Act was not designed to regulate the insurance business or to override any State regulatory scheme," and (2) "no legal basis exists for CSC to issue a regulation restricting the applicability of State laws to FEHB contracts." *Id.* The agency's lawyers informed the carriers that they did "not agree[]" that "the FEHB Act is exempt from State regulation." *Id.* To the contrary, as CSC's Deputy General Counsel explained, "the legislative history of the FEHB Act . . . indicates that State law should be controlling." *Id.* at 16; *see also id.* at ii (noting that the agency "has consistently taken the position that the States have the authority to regulate [FEHB carrier] plans").

Nevertheless, the agency understood the problem confronting FEHB carriers. These concerns led the Comptroller General (with CSC's blessing) to ask Congress to "consider legislation to clarify its intent as to whether State requirements should be permitted to alter terms of contracts negotiated pursuant to [FEHBA]." *Id.* at 17. Although CSC believed that, standing alone, FEHBA might be capable of "preempt[ing] State and local laws" "based on the Supremacy Clause," it advised Congress that "enforcement of this preemption policy" is not "necessary or desirable." H.R. Rep. No. 95-282, at 3 (1977). Instead, it recommended that Congress adopt a narrower express-preemption provision that "has more limited applicability." *Id.* Such a provision would, in the agency's view, "provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in [FEHB plans]." *Id.* at 3.

In 1978, Congress responded by adding a narrow express-preemption provision to FEHBA:

> The provisions of any contract under [FEHBA] which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1). The provision was then amended in 1998 to clarify that states could not limit the types of health care organizations that FEHBA carriers could use to provide benefits. *See* S. Rep. No. 105-257, at 15 (1998) ("These changes would affect states that have requirements governing what types of organizations can provide health care when those requirements are different from those under federal contracts."). In its current form, the clause states:

> The terms of any contract under [FEHBA] which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

In amending FEHBA to include this provision, Congress explained its intent: Because FEHBA did not give CSC "clear authority to issue regulations restricting the application of state laws when their provisions parallel the provisions in the [agency's] health benefits contracts," the express-preemption clause would "guarantee[] that the provisions of health benefits contracts made under [FEHBA] concerning benefits or coverage[] would preempt any state and/or local insurance laws and

regulations which are inconsistent with such contracts." S. Rep. No. 95-903 at 4.

In Congress's view, "[s]uch a preemption [clause]" was nevertheless "purposely limited and [would] not provide insurance carriers under the program with exemptions from state laws and regulations governing other aspects of the insurance business." *Id.*; *see also* H.R. Rep. No. 95-282 at 4-5 ("The effect of this amendment is to preempt the application of State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage when such laws or regulations conflict with the provisions of contracts under [FEHBA].").

2. As a federal employee, Respondent Jodie Nevils participated in a plan with Coventry serving as Nevils's OPM-approved medical insurance carrier. Pet. App. 2a. On November 2, 2006, Nevils was injured in an automobile accident. *Id.* at 16a. He received medical treatment for his injuries and, consistent with its obligations under the contract, Coventry paid the resulting bills. *Id.* At the time of Nevils's injuries, Coventry's OPM-approved contract directed it to "seek reimbursement or subrogation when an insured obtains a settlement judgment against a tortfeasor for payment of medical expenses." *Id.* at 45a.

After Nevils recovered from his injuries, he initiated a tort action against the negligent driver who caused the accident. The parties reached a settlement. *Id.* at 16a. Coventry (through its agent) then asserted a lien on the settlement funds for the medical bills it paid—a total of $6,592.24. *Id.* And Nevils paid the reimbursement amount to Coventry. *Id.*

In February 2011, Nevils filed suit in Missouri state court against Coventry, on behalf of himself and others

similarly situated, alleging that the insurer had improperly obtained reimbursement for medical benefits it paid because Missouri law prohibited its health insurers from demanding reimbursement from the settlement recoveries of injury victims. *Id.* at 29a-30a, 31a-32a; *see Benton House, LLC v. Cook & Younts Ins., Inc.*, 249 S.W.3d 878, 882 (Mo. App. 2008). Coventry defended the suit by arguing that FEHBA's preemption clause, § 8902(m)(1), preempts Missouri law.

3. The Missouri Supreme Court rejected Coventry's broad reading of § 8902(m)(1) and held that FEHBA does not preempt Missouri's state law prohibiting subrogation or reimbursement. The court's starting place was this Court's decision in *McVeigh*. Pet. App. 48a. As the Missouri Supreme Court explained, *McVeigh* "recognized that the FEHBA preemption clause is subject to plausible, alternate interpretations" on the question whether it preempts state laws that limit reimbursement or subrogation. *Id.* at 49a (citing *McVeigh*, 546 U.S. at 697). One could read the contract's reimbursement clause "as a condition or limitation on 'benefits' received by a federal employee," making the clause a "'contract term[] relating to coverage or benefits' and 'payments with respect to benefits,' thus falling within § 8902(m)(1)'s compass." *McVeigh*, 547 U.S. at 697. (alterations omitted). "On the other hand," the Court explained, "§ 8902(m)(1)'s words may be read to refer to contract terms relating to the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received, and not to terms relating to the carrier's postpayments right to reimbursement." *Id.* Given this ambiguity, the Missouri Supreme Court applied the presumption against preemption, and declined to displace Missouri's historic power over insurance and tort law. *Id* at 51a, 54a.

The court further held that its narrow reading of § 8902(m)(1) comported with well-established practice in insurance law. *Id.* at 53a. The "subrogation provision in favor of [Coventry] creates a contingent right to reimbursement and bears no immediate relationship to the nature, provision or extent of Nevis' insurance coverage and benefits," as required for FEHBA preemption. *Id.* Indeed, it noted, "Nevils would have been entitled to the same benefits had he never filed suit to recover damages for his injuries." *Id.* So subrogation and repayment may affect the parties' "net financial position *after* the provision of benefits," but it does not "affect the scope of coverage or the receipt of benefits." *Id.*

Judge Wilson, joined by Judge Breckenridge, concurred in the judgment. They concluded that "the preemption language in § 8902(m)(1) is not a valid application of the Supremacy Clause" and, "as a result, it has no effect." *Id.* at 56a. Reading § 8902(m)(1)'s plain language, they reasoned that Congress "plainly intended" to give the terms in Coventry's *contract* preemptive effect. *Id.* at 65a. But the "supremacy clause assigns primacy solely to federal *law*" and not to contracts later negotiated by federal agencies and private parties. *Id.* at 67a. "The idea that Congress claims the power to authorize the executive branch and private insurance companies to negotiate contract terms that Congress decrees—sight unseen—shall 'preempt and supersede' state law is such an unprecedented and unjustified intrusion on state sovereignty that it almost defies analysis." *Id.* at 66a.

Coventry petitioned for certiorari.

4. While Coventry's petition was pending, OPM jumped into the fray. Purporting to exercise its power under FEHBA's generic grant of agency authority to "prescribe regulations necessary to carry out this chapter," 5 U.S.C. § 8913, OPM issued a regulation directly

targeting the preemption issue in this case. *See* 5 C.F.R. § 890.106. In its final rule, the agency expansively interpreted FEHBA's preemption clause to preclude state subrogation and reimbursement laws. *See* OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29203 (May 21, 2015); 5 C.F.R. § 890.106(h). The new regulation provides:

> A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

Id.

The agency directed that its interpretation would "apply in any pending or future case." 80 Fed. Reg. at 29204. It offered no justification for its about-face, saying nothing to reconcile the new rule with its earlier position that, given FEHBA's general grant of rulemaking authority, "no legal basis exists" for the agency to issue "regulation[s] restricting the applicability of State laws to FEHB contracts." Comptroller Report, at 15.

In the wake of this intervening rule, the Solicitor General recommended that this Court remand the case to the Missouri Supreme Court. *See* Br. of U.S. as Amicus Curiae in support of petitions for certiorari at 12, *Coventry Health Care v. Nevils* and *Aetna Life Ins. v. Kobold* (Nos. 13-1305, 13-1467). Although the government claimed that OPM's regulation was "entitled to the full measure of deference under *Chevron*," it suggested

allowing the lower court "to consider in the first instance the question presented in light of the[] new regulations." *Id.* The Court remanded "for further consideration in light of new regulations promulgated by [OPM]." Pet. App. 73a.

5. On remand, the Missouri Supreme Court recognized that OPM's regulation does not—under this Court's precedents—deserve *Chevron* deference, and hence it had no reason to change its previous opinion. Pet. App. 5a. The majority opinion, signed by five of the seven judges, acknowledged the distinction between agency interpretation of "'the substantive (as opposed to pre-emptive) *meaning* of a statute'" and "'the question of *whether* a statue is pre-emptive.'" *Id.* at 9a (quoting *Smiley v. Citibank (S. Dakota), N.A.*, 517 U.S. 735, 744 (1996)). It observed that "*Chevron* has been applied repeatedly to determine the substantive meaning of a statute," based on—as here—general grants of agency authority to administer a statutory scheme. *Id.* at 5a.

But, the Missouri Supreme Court observed, "there is no indication that Congress delegated to the OPM the authority to make binding interpretations of the scope of the FEHBA preemption clause." *Id.* at 3a. And particularly without such a delegation, there is no U.S. Supreme Court authority holding that "*Chevron* deference applies to resolve ambiguities in a preemption clause." *Id.* at 5a.

Rather, the court explained that the "OPM rule does not alter the fact that the FEHBA preemption clause does not express Congress's clear and manifest intent to preempt Missouri's anti-subrogation law." *Id.* at 13a. And in light of that conceded uncertainty in § 8902(m)(1), the court again concluded that the presumption against preemption and the "cautious interpretation" mandated by this Court, *McVeigh*, 547 U.S. at 697, required upholding the State's law. Pet. App. 7a.

Judge Wilson, now joined by five other judges, concurred on the grounds that FEHBA's "attempt to give preemptive effect to provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause." *Id.* at 14a. Accordingly, in addition to the statutory construction described above, a majority of judges also opined that "for all of the reasons stated in" Judge Wilson's previous concurrence, their holding could be alternatively supported based on the Supremacy Clause violation.

6. Coventry again petitioned for certiorari, challenging both the statutory construction and the Supremacy Clause holdings.

ARGUMENT

I. The lower courts' conflict over FEHBA preemption reflects fundamental disagreements on questions of federalism and agency power.

Nevils does not deny that there is a split over whether FEHBA's express-preemption provision displaces state laws that prohibit insurance carriers from seeking reimbursement or subrogation from tort victims. The Missouri Supreme Court held that FEHBA preemption does *not* reach that far. Pet. App. 2a. And in doing so, it openly acknowledged that it was parting ways with the Arizona Court of Appeals and the Tenth Circuit. *Id.* at 12a ("declin[ing] to follow" *Kobold* and *Helfrich*).[1]

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[1] Coventry overstates the split by including the Georgia Supreme Court's decision in *Thurman v. State Farm Mutual Automobile Insurance Company*, 598 S.E.2d 448 (Ga. 2004). Pet. at 15. That case was decided before *McVeigh*, and, in any event, did not decide the preemption issue here. In *Thurman*, the carrier and injured federal employee *agreed* that the carrier was entitled to reimbursement, so the court only decided whether "funds from an insurance policy that are used to cover the subrogation claims of the federal

(continued ...)

Then, several months after the Missouri Supreme Court's decision here, the Eighth Circuit weighed in, disagreeing with the Missouri Supreme Court and opening a split between the state and federal courts in Missouri. *Bell*, 823 F.3d at 1204.

This conflict between the lower courts reveals deep uncertainty about fundamental questions that strike at the heart of the delicate balance between state and federal authority. Lower courts are not only split over the outcome—*i.e.*, whether § 8902(m)(1) bars state anti-subrogation laws—but they are also at odds over the reasons why. Resolving the split thus also means resolving broader matters of federalism and administrative power.

A. The division in authority over § 8902(m)(1) reflects an increasing disagreement over when to apply the presumption against preemption. As the Missouri Supreme Court recognized, preemption analysis "'starts with the basic assumption that Congress did not intend to displace state law.'" Pet. App. 6a (quoting *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981)). That is particularly true when Congress has intruded upon an area traditionally occupied by the states because "the states' historic police powers are not preempted unless it is the clear intent of Congress to preempt state law." *Id.* (citing *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) and *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992)). In that context, the Missouri Supreme Court explained, "when two plausible readings of a statute are possible," courts "'nevertheless have a duty to accept the

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government, as claimant's employer, [are] counted in the calculation of 'available coverages' for purposes of the Georgia Uninsured Motorists Statute." 598 S.E.2d at 450. The answer to that state-law question has no bearing on the preemption question here.

reading that disfavors pre-emption.'" Pet. App. 6a-7a (quoting *Bates v. Dow Agrosciences, LLC*, 544 U.S. 431, 449 (2005)).

The court found the presumption directly applicable here. Not only did this Court in *McVeigh* "recognize[] that the FEHBA preemption clause is subject to plausible, alternate interpretations," but it also warned that the provision's "unusual" prescription "warrants [a] cautious interpretation." Pet. App. 7a. Given these instructions, the Missouri Supreme Court held that Congress could not be said to have "expressed its clear and manifest intent that the purposes of FEHBA require the preemption of state anti-subrogation laws." *Id.* That conclusion was only reinforced by Coventry's claim for "dispositive deference to the new OPM rule," because—the Missouri Supreme Court aptly observed—the quest for *Chevron* deference "is a tacit admission that Congress did not express its clear and manifest intent" to preempt state anti-subrogation laws. *Id.*

The Arizona Court of Appeals has also held that the presumption applies. *See Kobold v. Aetna Life Ins. Co.*, 309 P.3d 924, 927 (Ariz. Ct. App. 2013) ("*Kobold I*"), *cert. granted, judgment vacated*, 135 S. Ct. 2886 (2015). Although it later determined that OPM's rule overrode both its initial conclusion and otherwise applicable canons of statutory interpretation, when it originally considered the issue the Arizona court began by "noting that preemption is disfavored." *Id.* Citing *Bates*, the court recognized that "when two plausible readings of a statute are possible, 'we would nevertheless have a duty to accept the reading that disfavors pre-emption.'" *Id.*

The two federal courts that have considered the issue, by contrast, have cast the presumption aside. In *Helfrich*, the Tenth Circuit acknowledged that this Court in *McVeigh* determined that FEHBA's express-

preemption provision "is ambiguous regarding the preemptive effect of reimbursement clauses." 804 F.3d at 1104. Yet it held that the "presumption does not apply here." *Id.* In its view, a "federal-interest exception to the general presumption against preemption" allowed the presumption to be discarded. *Id.* On that theory, the court reasoned, because the "preemption provision does not affect the relationships between private citizens" and "governs only contracts for the benefit of federal employees," the "federalism concern (respecting state sovereignty) behind the presumption . . . has little purchase in this case." *Id.* at 1105.

The Eighth Circuit in *Bell* held much the same thing. *See* 823 F.3d at 1201. Although it recognized that "health care in general is an area of traditional state regulation," it saw this case as "concern[ing] benefits from a federal health insurance plan for federal employees that arise from a federal law" and in which "[t]here is obviously a long history of federal involvement." *Id.* at 1201-02. "Whatever the force of the presumption against preemption as an interpretive tool," it reasoned, the canon "should not apply where 'considerable federal interests' are at stake.'" *Id.* (quoting *United States v. Locke*, 529 U.S. 89, 94 (2000)). It therefore found "no warrant to place a thumb on the scales against preemptive effect of the federal statute." *Id.*

The division among these four lower courts over the application of the presumption against preemption to FEHBA's ambiguous express-preemption clause is plainly ripe for review. This Court has, in the past, refused to discard the presumption based on either the existence of distinct federal interests or a long history of federal regulation in the area—precisely the reasons given by the Eighth and Tenth Circuits for rejecting the canon's application to FEHBA. *See, e.g.*, *Wyeth v. Levine*, 555 U.S. 555, 565 n.3 (2009) (dismissing claim that

the presumption "should not apply" because the federal government had "regulated drug labeling for more than a century," and noting that the argument "misunderstands the principle"—which "accounts for the historic presence of state law but does not rely on the absence of federal regulation").

Yet, at the same time, the Court has signaled that, in certain pockets of "*uniquely* federal areas of regulation," the presumption likely does not apply. *Chamber of Commerce v. Whiting*, 563 U.S. 582, 604 (2011) (emphasis added); *see, e.g.*, *Am. Ins. Ass'n v. Garamendi*, 539 U.S. 396, 401, 405-06 (2003) (presidential conduct of foreign policy); *Locke*, 529 U.S. at 108 (maritime commerce); *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 373-74 (2000) (foreign affairs power); *Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 352 (2001) (fraud on a federal agency); *Bonito Boats, Inc. v. Thunder Craft Boats, Inc.*, 489 U.S. 141, 143-44 (1989) (patent law).

Resolving this unsettled issue is critical in cases where, as here, the statutory language is subject to multiple plausible readings.

B. Adding to the disagreement, courts interpreting § 8902(m)(1)—even those reaching the same outcome with respect to § 8902(m)(1)—hold varying views on another major unresolved issue: whether *Chevron* deference applies to an agency's regulation construing the scope of a statute's express-preemption provision.

The Supreme Court of Missouri, as described above, held that it did not owe *Chevron* deference to OPM's interpretation of FEHBA's express-preemption clause. Pet. App. 5a. The court's decision was rooted in the need for express authority from Congress when an agency interprets the scope of its authority to preempt state laws generally rather than applicable substantive law. "The

fact that an agency regulation can have preemptive effect" through an interpretation of substantive statutory terms, the court explained, "does not mean that courts must defer to an agency rule purporting to define the preemptive scope of a statute administered by the agency." *Id.* at 10a n.3. Because interpreting the preemption clause implicates the careful federal-state balance of power, the Missouri Supreme Court held that it was not bound to defer to the agency's self-interested interpretation. *Id.* at 12a.

Both the Eighth Circuit and Tenth Circuit, however, sidestepped this question, in the process noting that "[t]he law concerning application of *Chevron* to an agency's view on preemption is unsettled." *Bell*, 823 F.3d at 1202. The Tenth Circuit, after surveying the relevant law, concluded that it was unclear whether OPM's regulation was entitled to more than "some weight" but refused to decide if *Chevron* deference applied. *Helfrich*, 804 F.3d at 1109. For the Eighth Circuit, it was "not clear that the law has evolved materially" since Justice O'Connor openly doubted that an agency regulation "determining the pre-emptive effect of any federal statute is entitled to deference." *Bell*, 823 F.3d at 1203 (quoting Justice O'Connor's concurrence in *Lohr*, 518 U.S. at 512). But, "like the Tenth Circuit in *Helfrich*," the Eighth Circuit held that it was "unnecessary to decide" whether OPM's regulation warranted *Chevron* deference because, in its view, "the better reading of the statute is that Arkansas law is preempted." *Id.*

The Arizona Court of Appeals, by contrast, was unable to skirt the *Chevron* question. It had already held, in *Kobold I*, that the better reading of § 8902(m)(1) was a narrow one, that state anti-subrogation laws fall "outside the scope" of the preemption provision's reach. 309 P.3d at 928. And it had also held that earlier informal efforts by OPM to require deference to a "contrary interpreta-

tion" were unpersuasive. *Id.* (refusing to accord *Chevron* deference to an informal agency letter). But, after reconsidering this view in light of OPM's newly final rule, it flipped. *See Kobold II*, 370 P.3d at 131 (holding that "the OPM regulations qualify substantively for *Chevron* deference").

In reaching this result, the Arizona Court of Appeals did not explain why it believed *Chevron* deference was appropriate for an agency's interpretation of a preemption provision. Instead, the court simply concluded that its hands were tied: Because OPM's interpretation was not *unreasonable*, the court believed *Chevron* deference "compels us to apply OPM's interpretation even though we view the analysis of *Kobold I* and *Nevils* as more faithful to the text of the statute." *Id.* at 131.

The upshot: there is an outcome-determinative split on the unsettled question whether *Chevron* deference attaches to agencies' interpretations of preemption provisions in the statutes they administer. One court has refused to accept OPM's bid for *Chevron* deference over its expansive interpretation of an ambiguous express-preemption clause, two courts have punted, and a fourth applied *Chevron* deference to displace state law even though, in its view, a more "faithful" reading of the statute respects state sovereignty.

C. Lastly, although most courts did not address the Supremacy Clause issue, the question whether Congress can endow the terms of possible future contracts with preemptive power is squarely presented here, and has profound implications for the Constitution's protection of federalism.

Coventry asserts that there is a conflict in authority over whether § 8902(m)(1) violates the Supremacy Clause. Pet. 30-32. That overstates the point. A six-judge majority of the Missouri Supreme Court has concluded

that § 8902(m)(1) violates the Supremacy Clause because the Constitution gives supreme power only to "laws," not contract terms. Pet. App. 12a. And then-judge Sotomayor flagged the issue when *McVeigh* was before the Second Circuit, explaining that "by unambiguously providing for preemption by contract," FEHBA's preemption provision is "highly problematic, and probably unconstitutional, because only federal *law* may preempt state and local law." *Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 143 (2nd Cir. 2005). There, in an effort to avoid the problem, the Second Circuit construed FEHBA to mean that "*federal law*"—not federal-government contracts with private insurers—preempts state law. But this Court did not adopt that rationale upon review in *McVeigh*, instead avoiding the issue altogether. This Court has therefore never had occasion to directly address the issue, leaving an open question.

Nevertheless, no other court evaluating the preemptive nature of § 8902(m)(1) since *McVeigh* has squarely addressed this question. The Eighth Circuit, for example, avoided finally deciding the issue because it held that the argument was waived below, and thus "forfeited." *Bell*, 823 F.3d at 1204. In dicta, the court registered its doubt that the provision was unconstitutional, noting that a court could adopt the "savings" construction like the one suggested by the Second Circuit in *McVeigh* itself. *Id.* But superficial musings about an explicitly forfeited constitutional argument are hardly enough to create a split. *See also Helfrich*, 804 F.3d at 1110 (expressing that it was "skeptical" of Supremacy Clause challenge, but because plaintiff "did not raise this argument below," the court "need not address it."); *Kobold II*, 370 P.3d 128 (not addressing Supremacy Clause issue).

Even without a clear split, the Supremacy Clause implications of an express-preemption clause that en-

dows private contracts with preemptive power is undeniably important. In *McVeigh*, this Court pointedly recognized that "FEBHA's preemption prescription . . . is unusual in that it renders preemptive contract terms in health insurance plans, not provisions enacted by Congress." *McVeigh*, 547 U.S. at 697. As a result, it delivered clear instructions about handling such a provision: "A prescription of that unusual order warrants cautious interpretation." *Id.* In the decision below, the Missouri Supreme Court faithfully followed these instructions. But a state's invalidation of a duly enacted federal statute—as here—is an important consideration for certiorari review. And the issue is unavoidable: The Court would have to resolve the constitutionality if FEHBA's express-preemption provision is to stand.

II. This case presents an optimal vehicle for deciding the full controversy.

If the Court is inclined to grant certiorari to resolve these unsettled issues, Nevils acknowledges that this case provides an optimal vehicle.

Most importantly, this case—as opposed to *Bell*, in which a petition for certiorari is forthcoming—squarely presents both the statutory-interpretation and Supremacy Clause questions. As Coventry notes, both issues were "thoroughly pressed and passed upon below." Pet. 35. This Court need not address the Supremacy Clause question if it agrees with the Missouri Supreme Court regarding § 8902(m)(1)'s construction. The narrow reading of § 8902(m)(1) required by this Court's jurisprudence would appropriately allow FEHBA to coexist with Missouri's reimbursement and subrogation laws, obviating the need to decide whether § 8902(m)(1) is unconstitutional in its entirety. And the canon of constitutional avoidance counsels that approach. *Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council*,

485 U.S. 568, 575 (1988) ("[W]here an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress.").

But, even if the Court disagrees on this point, it would need to reach the Supremacy Clause issue to harmonize the law between the federal and state courts in Missouri (and elsewhere). At present, *Bell* is the only other live case with the possibility of certiorari review. But it did not reach the Supremacy Clause question. *See Bell*, 823 F.3d at 1204. So, if this Court simply affirmed the Eighth Circuit's construction of § 8902(m)(1) (but declined to reach the Supremacy Clause question), the Missouri Supreme Court's conclusion that the provision is unconstitutional would remain intact—allowing the uncertainty surrounding the constitutionality of FEHBA's preemption clause to linger. Because a majority of judges on the Missouri Supreme Court joined Judge Wilson's concurrence opining that § 8902(m)(1) violates the Supremacy Clause, the court's holding could rest on constitutional grounds alone. In Missouri, then, the fate of the state's subrogation laws would continue to depend on whether a suit was filed in state or federal court.

In addition, the Eighth Circuit in *Bell* likewise failed to decide the question of *Chevron* deference. 823 F.3d at 1202 (noting only that the "application of *Chevron* to an agency's view on preemption is unsettled"). By contrast, the issue was thoroughly briefed and passed upon in the Missouri Supreme Court below. That court's decision provides concrete reasoning supporting its conclusion that *Chevron* does not apply here. As with the Supremacy Clause question, leaving the *Chevron*-deference issue unresolved does little to resolve the uncertainty surrounding these issues. This case is therefore a superior

vehicle for resolving the important federalism questions at stake.

III. The Missouri Supreme Court's construction of § 8902(m)(1) and constitutional analysis are correct.

The Missouri Supreme Court has twice thoroughly considered the reach of FEHBA's preemption provision. After reviewing this Court's decision in *McVeigh*, the text of FEHBA's preemption clause, the statute's considerable legislative history, and the relevant canons of statutory interpretation, the court correctly concluded that § 8902(m)(1) does not preempt state anti-subrogation laws. Following remand, the court also correctly refused to allow OPM to overturn that result by agency fiat. Absent express delegation from Congress, the court held that federal agencies do not have the authority to expand the scope of an express preemption clause, and courts are "not required to afford dispositive deference" to such an effort. Pet. App. 10a n.3. That holding also avoided a serious constitutional incursion. As a supermajority of the court explained, "FEHBA's attempt to give preemptive effect to the provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause." *Id.* at 14a (Wilson, J., concurring). These conclusions are all correct.

A. At this point, there should be no serious dispute that the text of FEHBA's preemption clause is ambiguous. This Court said so explicitly in *McVeigh* when it concluded that § 8902(m)(1) is open to more than one "plausible construction[]." *See* 547 U.S. at 697-98. OPM, too, has said the same thing. *See* Br. of U.S. as Amicus Curiae at 18, *Nevils v. Group Health Plan*, 492 S.W.3d 918 (Mo. 2016) (discussing § 8902(m)(1)'s "preexisting ambiguity").

Given this textual ambiguity, our system of dual sovereignty demands a "reading that disfavors preemption." *Altria Grp., Inc. v. Good*, 555 U.S. 70, 77 (2008). As this Court has repeatedly explained, one must "assume that a federal statute has not supplanted state law unless Congress has made such an intention 'clear and manifest.'" *Bates*, 544 U.S. at 449. The "effect of th[e] presumption," in other words, "is to support, where plausible, 'a narrow interpretation' of an express pre-emption provision." *CTS Corp. v. Waldburger*, 134 S. Ct. 2175, 2189 (2014) (Kennedy, J., concurring).

That is "especially" true when, as here, "Congress has legislated in a field traditionally occupied by the States.'" *Id.* (quoting *Altria*, 555 U.S. at 77). The twin areas of regulation at issue—insurance law and tort remedies—easily meet this definition. *See, e.g., New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (holding that health insurance is a "field[] of traditional state regulation" to which "presumption against pre-emption" applies); *CTS Corp.*, 134 S. Ct. at 2189 (Kennedy, J., concurring) ("In our federal system, there is no question States possess the 'traditional authority to provide tort remedies to their citizens' as they see fit."). *See also Bell*, 823 F.3d at 1201 (recognizing that health care "is an area of traditional state regulation").

In truth, this Court itself has all but mandated "a narrow interpretation" of FEHBA's express-preemption clause. Coventry asserts that the Missouri Supreme Court's interpretation of § 8902(m)(1) "departs fundamentally from this Court's teaching," Pet. 19, but that gets things exactly backwards. In *McVeigh*, after calling the provision "unusual" and "puzzling," the Court issued a cautionary directive: Given the clause's ambiguity and its declaration that terms in private contracts are preemptive, "a modest reading of the provision is in or-

der." 547 U.S. at 698. The narrow interpretation adopted below faithfully follows this instruction.

Reading § 8902(m)(1) "modest[ly]" makes even more sense in light of the rich historical evidence demonstrating that the law—from its inception—was designed precisely to avoid trampling state regulatory regimes. Both Congress and CSC repeatedly made clear that FEHBA was "not designed to regulate the insurance business or override any State regulatory scheme." Comptroller Report, at 15. Instead, states continued to hold the "authority to both regulate and tax" those health insurance carriers who participated in the federal program. *Id.* And Congress itself even told carriers that they had "no reason for circumventing compliance with applicable State laws."

Similarly limiting language was used to describe the passage of § 8902(m)(1). Far from "sweeping" (as Coventry describes it), the provision was "purposely limited" and, beyond the specifically identified benefit and provider laws, not intended to "provide insurance carriers . . . with exemptions from state laws and regulations" governing other matters. S. Rep 95-903, at 3.

Coventry ignores nearly all of this background, opting instead to argue that Congress's reference to uniformity and cost savings somehow overrides the actual limiting language that Congress used in the conference reports. Pet. 22-23. This Court has repeatedly rejected exactly this kind of argument before. Uniformity motivates literally every express-preemption clause, but that does not mean that every express-preemption clause displaces all state law. *Sprietsma v. Mercury Marine*, 537 U.S. 51, 70 (2002) (holding that, in absence of clear Congressional intent, "the concern with uniformity does not justify the displacement of state common-law remedies"). Instead, the question is how much of a balance

Congress intended to strike between a State's right to regulate and protect its citizenry, and the federal government's desire to displace that ability. *Altria*, 555 U.S. at 76 ("If a federal law contains an express pre-emption clause, it does not immediately end the inquiry because the question of the substance and scope of Congress' displacement of state law still remains.").

Here, Congress (and OPM) understood that carriers would have to tolerate state insurance regulation. With § 8902(m)(1), Congress intended to preempt—and promote uniformity—only for a clear subset of state laws: those regulating substantive benefits or coverage issues. The Missouri Supreme Court was right to reject Coventry's bid for more.

B. The Missouri Supreme Court also properly rejected OPM's unprecedented effort to override this conclusion. In *McVeigh*, this Court dealt the agency a major blow—rejecting OPM's claim that § 8902(m)(1) is "clear" and "no doubt" displaces "state laws that would affect the right to reimbursement." Br. of U.S. as Amicus Curiae at 20, *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006) (No. 05-200). But the agency has now doubled down in its attempt to expand its preemptive reach: In a transparent play for *Chevron* deference, OPM issued a formal regulation in the midst of this litigation. While conceding the textual ambiguity of FEHBA's express-preemption clause, OPM's rule purports to compel an expansive construction of FEHBA's preemption clause—one that authorizes contractual provisions in carrier contracts to displace state laws that OPM has long fought to evade. *See* § 890.106(h).

OPM's play for *Chevron* deference in the absence of congressional authority is misguided. Congress has in no way delegated OPM the authority to expand or interpret

FEHBA's express-preemption clause. Quite the opposite: As OPM's predecessor agency itself acknowledged at the time of § 8902(m)(1)'s enactment, "no legal basis exist[ed]" for it "to issue a regulation restricting the applicability of State laws to FEHB contracts." Comptroller Report, at 15. And it told Congress that, despite FEHBA's generic grant to "prescribe regulations to implement th[e] law," the statute "does not give [the agency] clear authority to issue regulations restricting the application of state laws." S. Rep. No. 95-903, at 4.

Yet OPM has now reversed course. Without any explanation for its shift, the agency asserts that the same generic grant of authority that precluded preemption by regulation forty years earlier now specifically authorizes it. This Court has specifically rejected similar "dramatic change[s] in [agency] position," especially when (as here) it centers on preemption. *See Wyeth*, 555 U.S. at 579. Because agencies are creatures of Congress, an agency wishing to interpret an express-preemption clause to preempt state law may validly do so only if Congress has expressly "authorized" it "to pre-empt state law directly." *Id.* at 576. FEHBA contains no such command.

Making matters worse, in its zeal to short-circuit the legislative and judicial process, OPM's regulation blithely tosses aside—without so much as a passing reference—bedrock principles of statutory construction that have long animated preemption jurisprudence. The "critical" point in any statutory interpretation case—one that "transcends debates about the mechanics of *Chevron*"—is that "[r]ules of interpretation bind all interpreters, administrative agencies included." *Carter v. Welles-Bowen Realty, Inc.*, 736 F.3d 722, 731 (6th Cir. 2013) (Sutton, J., concurring). Interpretive principles—which include "[a]ll manner of presumptions, substantive canons and clear-statement rules"—"take precedence over conflicting agency views." *Id.* at 731.

That holds true for agency efforts to override the presumption against preemption, *Comm. of Mass. v. U.S. Dep't of Transp.*, 93 F.3d 890, 895 (D.C. Cir. 1996), and it holds true where an agency advances an interpretation that "raises serious constitutional concerns," *U.S. West, Inc. v. FCC*, 182 F.3d 1224, 1231 (10th Cir. 1999). Because OPM's regulation is openly at war with these principles—indeed, its *raison d'etre* is to overturn them—*Chevron* does not sanction its enforcement.

Resolving disputes over a statute's meaning is ordinarily the job of the courts. Agency deference is the exception to this rule, but it is not something to which an agency is entitled simply through "[m]ere ambiguity in a statute," *Michigan v. EPA*, 268 F.3d 1075, 1082 (D.C. Cir. 2001), or because it has "expressed an interpretation in the proper form," *AKM LLC v. Secretary of Labor*, 675 F.3d 752, 765 (D.C. Cir. 2012) (Brown, J., concurring). To the contrary, it is Congress's "delegation of authority to the agency to elucidate a specific provision of the statute" that permits an agency's interpretation to be given deference at all. *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843-44 (1984). It is crucial that this Court safeguard this requirement, especially on questions directly implicating the delicate balance between state and federal sovereignty. OPM invites this Court to relax the limitations on its power and, in the process, to radically expand the ability of unelected bureaucrats to displace the federalism our Constitution demands. That invitation should be declined.

C. Finally, the Missouri Supreme Court was right to reject the idea that private contractual terms can preempt State laws—because the Supremacy Clause says no such thing. The Supremacy Clause of the Constitution states that "the Laws of the United States . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary

notwithstanding." U.S. Const. Art. VI, cl. 2. By its terms, § 8902(m)(1) provides that certain contractual terms will "supersede and preempt" state laws in a particular field. There is no constitutional authority for doing so.

The Supremacy Clause does not permit contract terms between private parties to reign "supreme" over state law. *See Arthur D. Little, Inc. v. Comm'r of Health and Hosps.*, 481 N.E. 2d 441, 452 (Mass. 1985) ("[T]his court has been unable to locate authority in this or any jurisdiction which supports the proposition that a contract to which the Federal government is a party somehow constitutes Federal law for purposes of the supremacy clause."); *United States v. Yazell*, 382 U.S. 341, 353 (1966) ("None of the cases in which [the Supreme Court] has devised and applied a federal principle of law superseding state law involved an issue arising from an individually negotiated contract."). A "Law," as used in the Supremacy Clause, "connotes official, government-imposed policies, not the terms of a private contract." *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 229 n.5 (1995); *see also id.* at 241 (O'Connor, J., concurring in part and dissenting in part) (noting that, "[t]o be sure, the terms of private contracts are not laws"). And "FEHBA-authorized contracts" "are not" laws. *McVeigh*, 396 F.3d at 144. They are instead "privately" negotiated agreements "with insurance providers who are under no obligation to enter into the contracts in the first place." *Id.*

For this reason, embracing a "highly problematic, and probably unconstitutional" reading of FEHBA's preemption clause, as then-Judge Sotomayor put it, *id.* at 143, should give any court pause, and the Missouri Supreme Court's decision to reject such a reading was both prudent and correct. *See DeBartolo*, 485 U.S. at 575. It concluded, consistent with FEHBA's legislative history and this Court's cautionary warning, that the

"statute's attempt to give preemptive effect to the provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause"—a conclusion that this Court should embrace.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of Missouri

REPLY BRIEF FOR PETITIONER

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RULE 29.6 STATEMENT

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

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REPLY BRIEF FOR PETITIONER

Respondent Jodie Nevils explicitly agrees that "certiorari should be granted" on both federal questions Coventry's petition presents. Resp. Br. 29. He could hardly do otherwise. Indeed, Nevils himself emphatically underscores many of the reasons Coventry identified why this Court's intervention is urgently warranted to resolve both questions. He candidly concedes (at 2, 12-20) that federal and state courts are irreconcilably split on the "important" question whether the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*—which governs health benefits of millions of federal employees and dependents—preempts state laws that prevent FEHBA carriers from seeking subrogation and reimbursement as required by their contracts with the Office of Personnel Management ("OPM"). And while Nevils implausibly denies the separate lower-court conflict regarding the constitutionality of FEHBA's express-preemption provision, *id.* § 8902(m)(1)—which a supermajority of the Missouri Supreme Court held invalid—he admits (at 20) that this constitutional question nevertheless merits this Court's review because the question is both "undeniably important" and in any event "unavoidable."

Nevils further expressly "acknowledges that this case provides an optimal vehicle" to decide both federal questions. Resp. Br. 20. Indeed, he agrees that "[t]his case ... is admittedly the *best* vehicle" to provide definitive guidance on these recurring questions that is either "available" now or likely to arise in the foreseeable future. *Id.* at 2 (emphasis added). A more clear-cut case for certiorari is difficult to fathom.

Nevils spends the remainder of his submission previewing his defense of the decision below on the merits. None of his contentions is well-taken; they simply repeat many of the errors in the Missouri Supreme Court's misguided statutory and constitutional holdings, which Nevils urges this Court (at 29) to "embrace." In any event, as Nevils necessarily acknowledges in expressly supporting certiorari (*ibid.*), none of his merits arguments provides any reason to forestall this Court's review.

Definitive resolution of the scope and validity of FEHBA's preemption provision is long overdue. And every imaginable obstacle to review in this case has now undisputedly been eliminated. This Court should grant review and correct the Missouri Supreme Court's distortions of federal law.

The petition should be granted.

I. BOTH QUESTIONS PRESENTED UNDISPUTEDLY MERIT THIS COURT'S REVIEW.

All agree that both questions Coventry's petition presents—concerning the correct interpretation and constitutionality of FEHBA's preemption provision, respectively—merit this Court's review. Both questions are undisputedly important and recurring, and each has fomented intractable lower-court confusion.

A. Nevils overtly "concedes" (at 2) that the first question presented—whether Section 8902(m)(1) encompasses state antisubrogation and antireimbursement laws—is "certworthy." He agrees (at 13) that this issue implicates "fundamental questions" of the intersection of federal and state law and agencies' role in administering federal statutes. And he does not dispute the stakes, which affect the benefits of millions of federal workers and family members.

Nevils also agrees (at 12) that "there is a split over whether FEHBA's express-preemption provision displaces state laws that prohibit insurance carriers from seeking reimbursement or subrogation from tort victims," which only this Court can resolve. He admits (at 12-13) that the Missouri Supreme Court's holding that FEHBA does not preempt such state laws (Pet. App. 5a-12a) directly conflicts with decisions of the Eighth and Tenth Circuits and the Arizona Court of Appeals, each of which has expressly held the opposite. *See Bell* v. *Blue Cross & Blue Shield of Okla.*, 823 F.3d 1198, 1200-05 (8th Cir. 2016); *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1109-10 (10th Cir. 2015); *Kobold* v. *Aetna Life Ins. Co.* (*Kobold II*), 370 P.3d 128, 130-32 (Ariz. Ct. App. 2016), *petition for review filed*, No. CV-16-0082-PR (Ariz. June 1, 2016). As Nevils notes (at 12-13), the decision below "openly acknowledged that it was parting ways with" *Helfrich* and *Kobold II*. And the Eighth Circuit in *Bell* in turn expressly "disagree[d] with the Missouri Supreme Court" here, thus "creat[ing] an untenable conflict between state and federal courts in the same state." *Id.* at 2, 13.*

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* Despite conceding the split and urging this Court to resolve it, Nevils curiously quibbles (at 12-13 n.1) over its precise scope, reprising his claim from his unsuccessful opposition to Coventry's prior petition that *Thurman* v. *State Farm Mutual Automobile Insurance Co.*, 598 S.E.2d 448 (Ga. 2004), did not decide the preemption issue. As Coventry and the United States each explained then, *Thurman* explicitly and necessarily decided the preemption issue in resolving the ultimate question of state insurance law: But for FEHBA, state law would have barred the insurer from seeking reimbursement out of the proceeds of the participant's settlement with a third party. *Id.* at 450-51; U.S. *Amicus* Br. 16, No. 13-1305 (U.S. May 22, 2015); Cert. Reply 2-3, No. 13-1305 (U.S. July 16, 2014). In any event, with or without *Thurman*, Nevils agrees (at 2) that the split is "certworthy."

B. Nevils also agrees (at 18-20) that the second question presented—whether Section 8902(m)(1) violates the Supremacy Clause, as the decision below held—merits this Court's review. He disputes (at 18-19) that the lower courts are divided on this issue, but he mischaracterizes or disregards their decisions.

Nevils admits (at 19) that *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 396 F.3d 136, 143 (2d Cir. 2005) (Sotomayor, J.), *aff'd*, 547 U.S. 677 (2006), directly addressed the issue, and resolved it by sensibly construing Section 8902(m)(1) to avoid the constitutional question. He urges the Court to ignore the Second Circuit's decision, however, because this Court *affirmed* that ruling without reaching the issue. But Nevils does not (and cannot) contend that this Court's ruling in *McVeigh* cast any doubt on the Second Circuit's analysis of that issue of Section 8902(m)(1)'s meaning. Tellingly, both the Eighth Circuit in *Bell* and the dissent from the Missouri Supreme Court's original opinion in this case—which six members of that court have now endorsed, and Nevils urges this Court to embrace—have understood then-Judge Sotomayor's opinion as still good law. 823 F.3d at 1204-05; Pet. App. 67a-71a.

Nevils downplays *Bell* (at 19) because the Eighth Circuit deemed the constitutional issue forfeited. But the court immediately *went on* to explain that it perceived no "obvious error" that would warrant *overlooking* that forfeiture—and in doing so expressly relied on the Second Circuit's conclusion in *McVeigh*. 823 F.3d at 1204. While it is true, as Nevils stresses (at 21), that that procedural posture makes *Bell* an inferior vehicle for certiorari, it does nothing to diminish the resulting lower-court disagreement or the need for this Court's intervention.

Nevils finally writes off the Arizona Court of Appeals' decision in *Kobold II*, which he describes (at 19) as "not addressing [the] Supremacy Clause issue." The Arizona court's opinion on its face refutes that description. As Coventry explained (Pet. 30-31), *Kobold II* considered and expressly rejected the claim that Section 8902(m)(1) violates "the Supremacy Clause because it gives preemptive effect to contract terms rather than federal law." 370 P.3d at 131 n.2.

In any event, Nevils's attempt to paper over this direct lower-court disagreement is academic because, as Nevils admits (at 19-20), the Missouri Supreme Court's holding that Section 8902(m)(1) violates the Supremacy Clause nevertheless warrants review. The constitutionality of that provision, and the ramifications for other preemption provisions that similarly tie the scope of preemption to particular contracts, from the Federal Arbitration Act, 9 U.S.C. § 2, to the Employee Retirement Income Security Act, 29 U.S.C. § 1144(a), are "undeniably important." Resp. Br. 20; *cf.* Pet. 33. And "a state's invalidation of a duly enacted federal statute—as here—is an important consideration for certiorari review," Resp. Br. 20, particularly where the statute affects a massive federal program serving millions of beneficiaries.

As Nevils acknowledges (at 20), moreover, the constitutional "issue is unavoidable: The Court would have to resolve the constitutionality" of Section 8902(m)(1) "if FEHBA's express-preemption provision is to stand." It would be wasteful and inefficient to decide *only* the statutory-interpretation question of Section 8902(m)(1)'s scope, because the Missouri Supreme Court has already made clear that, *whatever* the range of state laws this Court

holds Section 8902(m)(1) to preempt, in Missouri that provision is now a dead letter.

II. All Agree That This Case Is The Best Vehicle To Address Both Federal Issues.

Nevils also agrees (at 20) that, as Coventry demonstrated (Pet. 35-37), "this case provides an optimal vehicle" to decide both questions presented. As he underscores, "this case ... squarely presents both the statutory-interpretation and Supremacy Clause questions." Resp. Br. 20. Nevils acknowledges that "both issues were thoroughly pressed and passed upon below." *Ibid.* (internal quotation marks omitted). And, abandoning his meritless suggestion in unsuccessfully opposing Coventry's prior petition that the FEHBA contract did not authorize it to seek reimbursement, *cf.* Pet. 37; Br. in Opp. 15-19, No. 13-1305 (U.S. June 30, 2014), Nevils concedes (at 18) that whether FEHBA validly preempts Missouri's anti-subrogation law is "outcome-determinative" here.

Indeed, Nevils rightly notes that this case "is admittedly the *best* vehicle for finally resolving the important matters" Coventry's petition presents. Resp. Br. 2-3 (emphasis added). Although other federal and state courts have collectively rejected every plank of the Missouri Supreme Court's reasoning, "[t]his is the only live case presenting *all*" of the issues the case implicates: the best interpretation of Section 8902(m)(1)—either as an original matter, or pursuant to principles of deference to OPM's interpretation in a notice-and-comment regulation—and Section 8902(m)(1)'s constitutionality. *Id.* at 3 (emphasis added). If the Court were to decline review here, it would either have to await another case addressing *all* of those questions, grant review in multiple cases that each addressed only smaller pieces of

the larger puzzle, or decide one or more of the issues without the benefit of any ruling below.

Deferring review would be particularly imprudent because, as Nevil further notes, no viable candidates are on the immediate horizon. The "only other live case" with even a "possibility of certiorari review," he concedes (at 20-21), is the Eighth Circuit's decision in *Bell*, "in which a petition for certiorari is forthcoming." But as Nevils explains (at 21-22), this case is a "superior vehicle" to *Bell*—and Nevils should know, as his counsel of record here is also counsel of record for the eventual petitioner in *Bell*. *See Bell* v. *Blue Cross & Blue Shield of Okla.*, No. 16A163 (U.S. Sept. 13, 2016) (granting second extension application). As Nevils underscores (at 20-22), *Bell* does not cleanly present the constitutional issue, because the plaintiff's forfeiture of the constitutional challenge could prevent this Court from reaching that issue; and in rejecting the interpretation of Section 8902(m)(1) urged here by Nevils, the Eighth Circuit expressly reserved judgment on whether OPM's interpretation is entitled to dispositive deference under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984); *see* 823 F.3d at 1202-05.

Nevils's admission that the only other potential vehicle—being handled by his own counsel, and which may not be fully briefed for months—is inferior to this case tells the Court everything it needs to know. The Court should seize the opportunity this case provides to resolve all of the important federal questions this case presents without delay.

III. NEVILS'S DEFENSES OF THE DECISION BELOW ARE IRRELEVANT AND UNSUSTAINABLE.

Having cemented the case for certiorari, Nevils turns (at 22-29) to prefiguring his defense of the Missouri Supreme Court's holdings on the statutory and constitutional merits. He does not pretend that his arguments, even if well-founded, provide any reason to decline review here. Quite the contrary, Nevils concludes (at 29) by explicitly urging that Coventry's petition "should be granted" precisely because of the importance of these issues and the confusion they have fomented. The Court accordingly need not tarry over Nevils's merits arguments now, but should grant plenary review to resolve both questions after full briefing and argument. Lest Nevils's contentions leave the misimpression that the merits questions are close, however, a brief response is warranted.

A. Nevils defends (at 22-25) the Missouri Supreme Court's crabbed reading of Section 8902(m)(1), but tellingly never addresses its *text*. The statute expressly "preempt[s] any State or local law" that prevents enforcement of "[t]he terms of any contract" under FEHBA which "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). Nevils offers no way to square the Missouri court's construction with that text even standing alone, still less with that text read in light of this Court's precedents construing similar preemption provisions, *cf.* Pet. 19-22—precedents Nevils never mentions.

Nevils begins instead (at 22-24) with the presumption against preemption. But he disregards this Court's recent, controlling holding that the presumption is categorically inapplicable to express-preemption provisions such as Section 8902(m)(1).

See Puerto Rico v. *Franklin Cal. Tax-Free Trust*, 136 S. Ct. 1938, 1946 (2016). And Nevils's assertion (at 23) that *federal* contracts with a *federal* agency governing benefits of *federal* employees under a *federal* statute somehow implicate a traditional *state-law* domain is as strained as it sounds. *Cf.* Pet. 28.

In any event, the presumption does not help Nevils because, never engaging with the text at all, he necessarily fails to identify any genuine ambiguity. His *best* evidence of supposed ambiguity is dictum in *McVeigh*, 547 U.S. 677, which Nevils claims "all but mandate[s] 'a narrow interpretation'" of Section 8902(m)(1). Resp. Br. 22-23 (citation omitted). But as Coventry and the government have explained, far from mandating a narrow construction or even establishing ambiguity, *McVeigh* expressly *reserved judgment* on Section 8902(m)(1)'s scope. 547 U.S. at 698 ("we need not choose between" proffered interpretations); *see* Pet. 22; Pet. App. 181a-82a.

Nevils also quotes a passing allusion in the government's brief below to "'preexisting ambiguity,'" but clips that phrase out of context. Resp. Br. 22 (citation omitted). What the quoted sentence said was that "[t]he agency's [*i.e.*, OPM's] rule, in short, authoritatively resolved *any* preexisting ambiguity in the statute." Pet. App. 201a-02a (emphasis added). The government, moreover, had already told the Missouri Supreme Court—in this case, years after *McVeigh*—that "§ 8902(m)(1) *unambiguously* preempts Missouri's anti-subrogation rule." *Id.* at 175a (emphasis added) (capitalization omitted). Nevils's defense of the Missouri Supreme Court's statutory analysis only underscores its serious errors.

B. Nevils's unsubstantiated assertion of ambiguity gets him nowhere because courts "presum[e] that Congress, when it left ambiguity in [the] statute meant for implementation by an agency, understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows." *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735, 740-41 (1996). Congress expressly empowered OPM to administer FEHBA, including by promulgating regulations, 5 U.S.C. § 8913(a), and OPM exercised that authority here to codify its pro-preemption interpretation of Section 8902(m)(1) in a notice-and-comment regulation that carries the force of federal law, 5 C.F.R. § 890.106(h). Under *Chevron* and decades of this Court's decisions since, OPM's interpretation controls if it is "reasonable." *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 (2009). Even the Missouri Supreme Court did not suggest that OPM's reading fell short of that threshold.

Nevils does not attempt to defend the reason the Missouri Supreme Court *did* give for nevertheless withholding deference: its sweeping pronouncement that *Chevron* is categorically inapplicable to express-preemption provisions. Pet. App. 5a, 9a-12a. As Coventry showed, that position runs headlong into this Court's cases—including *Smiley*, 517 U.S at 744, and *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 496-97 (1996), which deferred to federal agencies' reasonable interpretations of the scope of federal statutes that preempted state law. *Cf.* Pet. 25-27. Nevils has no answer to these precedents.

Instead, Nevils tries (at 25-26) to evade deference by asserting that OPM's regulation departs from its (really, its predecessor's) position. An agency's change of position, however, is irrelevant to the degree of deference owed under *Chevron*. *See Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 981 (2005). In any event, as Coventry showed in detail below, Nevils's claim of agency inconsistency is pure fiction. The sources Nevils cites (at 26)—principally a 1975 report by the Comptroller General—show only that, *before* Congress enacted FEHBA's express-preemption provision in *1978*, there was uncertainty whether OPM's predecessor (the Civil Service Commission) could issue regulations addressing preemption. Coventry Mo. S. Ct. Br. 73-77 (Nov. 16, 2015). Congress enacted Section 8902(m)(1) specifically to "clear up the doubt and confusion" regarding the agency's "clear authority to issue regulations restricting the application of state laws." S. Rep. No. 95-903, at 4 (1978). OPM (created the same year) has understood Section 8902(m)(1) "since Congress enacted it in 1978" as preempting state antisubrogation and antireimbursement laws, and its 2015 regulation simply "formalize[d]" that well-settled understanding in a binding rule. OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29,203, 29,204 (May 21, 2015).

C. Nevils's defense of the Missouri Supreme Court's separate holding striking down Section 8902(m)(1) as violating the Supremacy Clause likewise only magnifies the court's errors. Nevils recites (at 27-28) the truism that only "Laws" are "supreme." But he never addresses the obvious solution to the purported constitutional puzzle he poses: Section 8902(m)(1) is best read as giving *federal law* preemp-

tive force, simply defining the *scope* of preemption by reference to contracts, as many statutes do. Pet. 30-31. At a minimum, as the Second and Eighth Circuits have held, the statute "reasonably" can, and therefore *must*, be so construed, which avoids any constitutional concern. *McVeigh*, 396 F.3d at 144; *Bell*, 823 F.3d at 1204-05.

Nevils suggests (at 28) that the avoidance canon *supports* the decision below, but its holding completely inverts that principle. Rather than sensibly construing FEHBA to avoid a constitutional problem, the court below needlessly construed the statute to *create* one—and proceeded to invalidate Section 8902(m)(1) *in toto*. That holding eviscerates the preemption provision and puts the fair and efficient administration of the FEHBA program in jeopardy.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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October 11, 2016

AND
BRIEFS

Supreme Court, U.S.
FILED
DEC 19 2016
OFFICE OF THE CLERK

No. 16-149

IN THE
Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ Of Certiorari
To The Supreme Court Of Missouri

JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI FILED
AUGUST 1, 2016
CERTIORARI GRANTED NOVEMBER 4, 2016

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Comptroller General of the United States, Gen. Accounting Office, Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers (1975) 545

NOTICE

The following documents have been omitted in printing this joint appendix because they appear on the following pages in the appendix to the petition for a writ of certiorari:

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Opinion of the Supreme Court of Missouri, 418 S.W.3d 451 (Feb. 4, 2014) 44a

Order of the Supreme Court of the United States Granting Certiorari, Vacating, and Remanding, No. 13-1305, 135 S. Ct. 2886 (June 29, 2015) 73a

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11SL-CC00535 - JODIE NEVILS V GROUPHEALTH PLAN INC (E-CASE)
Docket Entries

04/01/2011 **Removed to Fed Court**

03/31/2011 **Certification Filed**
Clerk's certification.

Notice
Notice of filing of removal

03/11/2011 **Agent Served**
Document ID - 11-SMCC-1962; Served To - GROUP HEALTH PLAN INC; Server - ; Served Date - 02-MAR-11; Served Time - 00:00:00; Service Type - Special Process Server; Reason Description Served

02/14/2011 **Summons Issued-Circuit**
Document ID: 11-SMCC-1962, for GROUP HEALTH PLAN INC. - MAILED TO ATTORNEY

02/09/2011 **Filing:**
FILING INFORMATION SHEET

Pet Filed in Circuit Ct

Judge Assigned
DIV 3

11SL-CC00535-01 - JODIE NEVILS V GROUPHEALTH PLAN INC
Docket Entries

07/31/2012 **Certif Copies/Leg File Prepard**
Certified Copy of Supplement to Legal File Prepare for S. TO, ATTORNEY FOR THE APPELLANT.

06/12/2012 **Ackn Notice of Appeal Filed**

06/08/2012 **Certif Copies/Leg File Prepared**
Certified Copy of Legal File Prepared FOR S. TO, ATTORNEY FOR THE APPELLANT.

06/05/2012 **Judge/Clerk - Note**
COPY OF JODIE NEVILS, PLAINTIFF NOTICE OF APPEAL MAILED TO MISSOURI COURT OF APPEALS WITH CHECK # 21SL1721297. FORWARDED COPIES OF PLAINTIFF'S NOTICE OF APPEAL BY REGULAR MAIL TO THOMAS DEE 190 CARONDELET PLAZA STE. 600 ST. LOUIS, MO. 63105 & WINTHROP REED 600 WASHINGTON AVE., STE. 2500 ST. LOUIS, MO. 63101.

05/29/2012 **Appeal Filed**
NOTICE OF APPEAL FILED & $70.00 FEE PAID BY APLT STEPHANIE H. TO; #61149; REC# 21SL1721297;

JODIE NEVILS APPEALS
Filed By: JODIE NEVILS

Appeal Costs Taxed
NOTICE OF APPEAL FILED & $70.00 FEE PAID BY APLT STEPHANIE H. TO #61149; PLT JODIE NEVILS APPEALS
Filed By: JODIE NEVILS

05/21/2012 **Judgment Entered**
DFT Group Health Plan Inc.'s Motion for Summary Judgment is Granted DFT ACS Recovery Services Inc,'s Motion for Summary Judgment is Granted All other orders per memo SO ORDERED: JUDGE THEA A. SHERRY

Other Final Disposition

04/16/2012 **Response Filed**
to Notice of Supplemental Authority
Filed By: ACS RECOVERY SERVICES INC

04/13/2012 **Response Filed**
to Notice of Supplemental Authority
Filed By: GROUP HEALTH PLAN INC

Response Filed
to Notice of Supplemental Authority
Filed By: GROUP HEALTH PLAN INC

04/04/2012 **Filing:**
Notice of Supplemental Authority
Filed By: JODIE NEVILS

02/24/2012 **Memorandum Filed**
DEFENDANT ACS' MEMORANDUM TO THE COURT IN RESPONSE TO PLAINTIFF'S LETTER

02/21/2012 **Correspondence Filed**
LETTER FILED
Filed By: JOHN ERIC CAMPBELL

01/27/2012 **Motion Hearing Held**
MTN FOR SUMMARY JUDGMENT CALLED. MTN'S TAKEN UNDER SUBMISSION SO ORDERED: JUDGE SHERRY
Scheduled For: 01/27/2012; 1:30 PM ; THEA A SHERRY; St Louis County

01/26/2012 **Reply**
REPLY OF ACS RECOVERY SVC IN SUPPORT OF MTN FOR SUMMARY JUDGMENT
Filed By: JOHN ERIC CAMPBELL

01/23/2012 **Order Granting Ext of Time**

01/11/2012 **Filing:**
PLT'S OPPOSITION TO DFT ACS RECOVERY SERVICES INC'S

MOTION FOR SUMMARY JUDGMENT

01/04/2012 **Order of Dismissal**
STIPULATION OF DISMISSAL FILED. COUNTERCLAIMANT/DEFENDANT ACS RECOVERY SERVICES DISMISSES ITS COUNTERCLAIM WITHOUT PREJUDICE. SO ORDERED: JUDGE SHERRY

12/30/2011 **Judge Assigned**
Cause reassigned to Judge Thea A. Sherry for hearing and determination effective January 1, 2012, per Presiding Judges Administrative Order.

12/20/2011 **Motion for Extension of Time**
Motion for Extension of Time to file a Responsive or Answer to Defendant ACS Recovery Service Counterclaim
Filed By: JODIE NEVILS

12/15/2011 **Motion Filed**
MOTION TO APPLY SUMMARY JUDGMENT
Filed By: GROUP HEALTH PLAN INC

12/14/2011 **Correspondence Sent**
Copy of Notices Filed and Mailed This Day to the Parties of Record.

12/13/2011 **Motion for Leave**
Filed By: JODIE NEVILS

Reply
PLT'S PROPOSED SUR REPLY
Filed By: JODIE NEVILS

12/01/2011 **Memorandum Filed**
MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT
Filed By: ACS RECOVERY SERVICES INC

Motion for Summary Judgment
AND STATEMENT OF UNCONTROVERTED FACTS
Filed By: ACS RECOVERY SERVICES INC

11/22/2011 **Answer Filed**
FIRST AMENDED ANSWER, AFFIRMATAIVE DEFENSES AND COUNTERCLAIM TO FIRST AMENDED CLASS ACTION PETITION
Filed By: ACS RECOVERY SERVICES INC

Reply
MEMORANDUM IN SUPPORT OF MT FOR SUMMARY JUDGMENT
Filed By: GROUP HEALTH PLAN INC

11/09/2011 **Answer Filed**
AND AFFIRMATIVE DEFENSES TO FIRST AMENDED PETITION
Filed By: GROUP HEALTH PLAN INC

11/07/2011 **Order Granting Ext of Time**
Unopposed Request for Extension of Time Copeis mailed SO ORDERED: JUDGE ELLEN LEVY SIWAK

Order of Dismissal
Cross-Claim Plaintiff ACS Recovery Services, Inc., DISMISSES its Cross Claim without prejudice Copies mailed SO ORDERED: JUDGE ELLEN LEVY SIWAK
Associated Entries: 08/26/2011 - Cross Claim Filed

11/04/2011 **Answer Filed**
AFFIRMATIVE DEFENSES AND COUNTERCLAIM
Filed By: ACS RECOVERY SERVICES INC

11/01/2011 **Order**
Cosent for Plaintiff's First Amended Class Action Peittion For Damages Copies handed SO ORDERED: JUDGE ELLEN LEVY SIWAK
Associated Entries: 10/31/2011 - Amended Motion/Petition Filed

10/31/2011 **Amended Motion/Petition Filed**
First Amended Class Action Peittion For Damages
Filed By: JODIE NEVILS
Associated Entries: 11/01/2011 - Order

10/27/2011 **Motion Hearing Scheduled**
DFTS MOTION FOR SUMMARY JUDGMENT
Associated Entries: 01/27/2012 - Motion Hearing Held
Scheduled For: 01/27/2012; 1:30 PM ; THEA A SHERRY; St Louis County

Notice of Hearing Filed
DFTS MOTION FOR SUMMARY JUDGMENT
Filed By: MELISSA ZIGLER BARIS

10/21/2011 **Response Filed**
IN OPPOSITION TO DEFT'S MT FOR SUMMARY JUDGMENT W/SUGGESTIONS IN SUPPORT
Filed By: JODIE NEVILS

10/20/2011 **Certificate of Service**

10/06/2011 **Order**
ORDER SUSTAINING PLTS MOTION FOR EXTENSION OF TIME THE COURT TAKES UP AND CONSIDERS

PLTS MOTION FOR EXTENSION OF TIME IN WHICH TO RESPOND TO DFTS MOTION FOR SUMMARY JUDGMENT AND AFTER BEING FULLY AND DULY ADVISED IN THE PREMISES HEREBY SUSTAINS THE MOTION PLTS RESPONSE TO DFTS MOTION FOR SUMMARY JUDGMENT IS NOW DUE 10/20/11 COPIES MAILED TO ATTYS OF RECORD (10/6/11) SO ORDERED: JUDGE ELLEN LEVY SIWAK

Motion Granted/Sustained
PLTS MOTION FOR EXTENSION OF TIME SO ORDERED: JUDGE ELLEN LEVY SIWAK

Associated Entries: 10/04/2011 - Motion Filed

Order
HAVING BEEN APPRISED THAT NO PARTY OBJECTS TO MOTIONT O INTERVENE AND FOR GOOD CUASE SHOWN, MOTION TO INTERVENE GRANTED ON BASIS THAT IT IS UNOPPOSED MOTION HEARING IS CANCELED COPIES MAILED TO ATTYS OF RECORD SO ORDERED: ELLEN LEVY SIWAK

Hearing/Trial Cancelled

Scheduled For: 11/10/2011; 9:00 AM ; ELLEN LEVY SIWAK; St Louis County

Motion Granted/Sustained
MOTION TO INTERVENE SO ORDERED: JUDGE ELLEN LEVY SIWAK
Associated Entries: 09/16/2011 - Filing:

10/04/2011 **Motion Filed**
PLTS MOTION FOR EXTENSION OF TIME TO RESPOND TO DFTS MOTION FOR SUMMARY JUDGMENT W/ATTACHED FAX COVER SHEET
Filed By: JODIE NEVILS
Associated Entries: 10/06/2011 - Motion Granted/Sustained

09/16/2011 **Filing:**
APPLICANT ACS'S UNOPPOSED SUPPLEMENTAL MEMORANDUM IN SUPPORT OF MT TO INTERVENE
Associated Entries: 10/06/2011 - Motion Granted/Sustained

09/12/2011 **Memorandum Filed**

09/08/2011 **Motion Hearing Scheduled**
Associated Entries: 10/06/2011 - Hearing/Trial Cancelled
Scheduled For: 11/10/2011; 9:00 AM ; ELLEN LEVY SIWAK; St Louis County

09/07/2011 **Filing:**
STATEMENT OF UNCONTROVERTED MATERIAL FACTS IN SUPPORT OF MT SUMMARY JUDGMENT
Filed By: GROUP HEALTH PLAN INC

Filing:
SUGGESTIONS IN SUPPORT OF MT FOR SUMMARY JUDGMENT
Filed By: GROUP HEALTH PLAN INC

Motion for Summary Judgment
Filed By: GROUP HEALTH PLAN INC

08/26/2011 **Motion to Intervene**
Filed By: STEVEN DAVID HALL

Cross Claim Filed
CROSS-CLAIM OF PLAINTIFF/INTERVENOR ACS RECOVERY SERVICES, INC., AGAINST PLAINTIFF YOUNG FOR A DECLARATORY JUDGMENT FILED.
Filed By: STEVEN DAVID HALL
Associated Entries: 11/07/2011 - Order of Dismissal

Entry of Appearance Filed
ENTER THEIR APPEARANCE AS ATTORNEYS FOR APPLICANT ACS RECOVERY SERVICE
Filed By: STEVEN DAVID HALL

08/25/2011 **Certificate of Mailing**

07/15/2011 **Answer Filed**
Deft's Answer and Affirmative Defenses
Filed By: GROUP HEALTH PLAN INC

07/11/2011 **Filing:**
COPY OF NOTICE FILED AND MAILED TO PARTIES OF RECORD

07/07/2011 **Motion Granted/Sustained**
Plf's motion for change of judge, granted
SO ORDERED: JUDGE MARK D. SEIGEL
Associated Entries: 07/06/2011 - Motion for Change of Judge

Judge Assigned
The Above Cause is Assigned to Division 11, By Order of the Presiding Judge, For Hearing and Determination. Notice Mailed This Day to Parties of Record and Copy Filed.

07/06/2011 **Motion for Change of Judge**
Filed By: JOHN ERIC CAMPBELL
Associated Entries: 07/07/2011 - Motion Granted/Sustained

06/15/2011 **Order**
COPY OF MEMORANDUM AND ORDER OF REMAND

11SL-CC00535-02 - JODIE NEVILS V GROUPHEALTH PLAN INC
Docket Entries

06/21/2016 **Order for Stay**
SO ORDERED: JUDGE ELLEN LEVY SIWAK
Associated Entries: 06/16/2016 - Proposed Order Filed

Hearing/Trial Cancelled
Stay Order Granted
Scheduled For: 06/24/2016; 9:00 AM ; ELLEN LEVY SIWAK; St Louis County

06/16/2016 **Proposed Order Filed**
Proposed Order; Electronic Filing Certificate of Service.
Filed By: THOMAS N STERCHI
On Behalf Of: GROUP HEALTH PLAN INC
Associated Entries: 06/21/2016 - Order for Stay

Motion to Stay
JOINT MOTION OF ALL PARTIES TO STAY PROCEEDINGS; Electronic Filing Certificate of Service.
Filed By: THOMAS N STERCHI
On Behalf Of: GROUP HEALTH PLAN INC

05/23/2016 **Mandate from Supreme Ct of MO**
The judgment by the Circuit Court of St. Louis County be reversed, annulled and for naught held and esteemed, and that the said Appellant be restored to all things which he has lost by reason of said judgment. It is further considered and adjudged by the court that the said cause be remanded to the said Circuit Court of St. Louis County for further proceedings to be had therein, in conformity with the opinion of this court herein delivered; and that the said Appellant recover against the said Respondents costs and charges herein expended, and have execution therefor.
**********OPINION FILED**********

09/22/2015 **Counsel Status Hrng Scheduled**
SO ORDERED: JUDGE ELLEN LEVY SIWAK

Associated Entries: 06/21/2016 - Hearing/Trial Cancelled
Scheduled For: 06/24/2016; 9:00 AM ; ELLEN LEVY SIWAK; St Louis County

08/26/2015 **Judge/Clerk - Note**
MANDATE FROM MISSOURI SUPREME COURT, FILED ON FEBRUARY 24, 2014, RETURNED TO SUPREME COURT AS REQUESTED.

08/14/2015 **Correspondence Filed**
LETTER RECEIVED FROM MISSOURI SUPREME COURT, REQUESTING RETURN OF MANDATE FILED ON FEBRUARY 24, 2014.

02/19/2015 **Hearing/Trial Cancelled**
See 4/3/14 Order to Stay
Scheduled For: 03/18/2015; 12:00 AM ; ELLEN LEVY SIWAK; St Louis County

02/10/2015 **Correspondence Sent**

Dismissal Hearing Scheduled
Associated Entries: 02/19/2015 - Hearing/Trial Cancelled
Scheduled For: 03/18/2015; 12:00 AM ; ELLEN LEVY SIWAK; St Louis County

01/15/2015 **Order of Dismissal**
Defendant Xerox REcovery Services, Inc ONLY Dismiissed with prejudice SO ORDERED: JUDGE ELLEN LEVY SIWAK

01/05/2015 **Notice of Dismissal**
Notice of Dismissal of Defendant ACS; Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS
On Behalf Of: JODIE NEVILS

12/31/2014 **Judge Assigned**
Cause reassigned to Judge Ellen Levy Siwak for hearing and determination effective January 1, 2015, per Presiding Judges Administrative Order.

12/03/2014 **Hearing/Trial Cancelled**
Scheduled For: 12/03/2014; 9:00 AM ; THEA A SHERRY; St Louis County

04/29/2014 **Case Mgmt Conf Scheduled**
Associated Entries: 12/03/2014 - Hearing/Trial Cancelled
Scheduled For: 12/03/2014; 9:00 AM ; THEA A SHERRY; St Louis County

Order
On the Court's own motion, the Court sets this matter for a status/case management conference on December 3, 2014 at 9:00 a,m, unless there has been a final disposition with regard to the petition for Writ of Certiorari before the Supreme Court prior to that date. Copies sent to attorneys of record SO ORDERED: JUDGE THEA A. SHERRY

04/03/2014 **Order**
Upon Joint Motion of all parties to this action, and for good cause shown, it is hereby Ordered that: 1. All further proceedings on this action are hereby stayed until such time as the United

States Supreme Court finally disposes of Defendants' petition for writ of certiorari, including any briefing and argument on the merits and issuance of any opinion. 2. Defendants shall apprise this Court of any final disposition by the United States Supreme Court with regard to its petition for writ of certiorari, within 10 days of such disposition. 3. The Case Management Conference scheduled for April 2, 2014 is hereby adjourned without date. Copies mailed to attorneys of record. SO ORDERED: JUDGE THEA A. SHERRY

Hearing/Trial Cancelled
Scheduled For: 04/16/2014; 9:00 AM ; THEA A SHERRY; St Louis County

03/31/2014 **Case Mgmt Conf Scheduled**
Comes now Coventry Health Care and with consent of counsel requests the court to remove the case management conference from the April 2, 2014 docket and reset the case management conference for April 16, 2014 at 9:00 a.m. SO ORDERED: JUDGE THEA A. SHERRY
Associated Entries: 04/03/2014 - Hearing/Trial Cancelled
Scheduled For: 04/16/2014; 9:00 AM ; THEA A SHERRY; St Louis County

Hearing Continued/Rescheduled
Hearing Continued From:

04/02/2014; 9:00 AM Case Management Conference

03/27/2014 **Entry of Appearance Filed**
Filed By: THOMAS N STERCHI

Motion to Withdraw
Motion to withdraw as counsel. SO ORDERED: JUDGE THEA A. SHERRY
Filed By: MELISSA ZIGLER BARIS

Motion Filed
Joint motion of all parties to stay proceedings

02/28/2014 **Case Mgmt Conf Scheduled**
Associated Entries: 03/31/2014 - Hearing Continued/Rescheduled
Scheduled For: 04/02/2014; 9:00 AM ; THEA A SHERRY; St Louis County

Notice of Hearing Filed
Copies sent to parties of record SO ORDERED: JUDGE THEA A. SHERRY

02/21/2014 **Reopen From Mandate**

U.S. DISTRICT COURT
Eastern District of
Missouri (St. Louis)
CIVIL DOCKET FOR CASE #:
4:11-cv-00588-DDN

Nevils v. Group Health Plan, Inc.
Assigned to: Magistrate Judge David D. Noce
Case in other court: St. Louis County Circuit Court, 11ST-CC00535
Cause: 05:8901 Federal Employees Health Benefits Act

Date Filed: 03/31/2011
Date Terminated: 06/16/2011
Jury Demand: None
Nature of Suit: 890 Other Statutory Actions
Jurisdiction: Federal Question

Date Filed	#	Docket Text
03/31/2011	1	NOTICE OF REMOVAL from St. Louis County Circuit Court, case number 11SL-CC00535, with receipt number 0865-2693554, in the amount of $350 Jury Demand,, filed by Group Health Plan, Inc.. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C, # 4 Exhibit D, # 5 Exhibit E, # 6 Exhibit F, # 7 Exhibit G, # 8 Exhibit H, # 9 Exhibit I, # 10 Exhibit J, # 11 Original Filing Form, # 12 Civil Cover Sheet, # 13 Certificate of Interest, # 14 Entry of

		Appearance of Thomas Dee)(Dee, Thomas) (Entered: 03/31/2011)
03/31/2011	2	NOTICE OF FILING NOTICE OF REMOVAL filed by Defendant Group Health Plan, Inc. Sent To: St. Louis County Circuit Court executed by State Court Clerk (Dee, Thomas) (Entered: 03/31/2011)
03/31/2011	3	DISCLOSURE OF CORPORATION INTERESTS CERTIFICATE by Defendant Group Health Plan, Inc. (KLK) (Entered: 04/01/2011)
03/31/2011	4	Complaint (Removal) Received From: St. Louis County Circuit Court filed by Jodie Nevils.(KLK) (Entered: 04/01/2011)
04/01/2011	5	ENTRY of Appearance by Melissa Z. Baris for Defendant Group Health Plan, Inc.. (Baris, Melissa) (Entered: 04/01/2011)
04/01/2011	6	ENTRY of Appearance by Elizabeth A. Mushill for Defendant Group Health Plan, Inc.. (Mushill, Elizabeth) (Entered: 04/01/2011)
04/01/2011		Case Opening Notification. Consents issued 2. Judge Assigned: Honorable David D. Noce. (KLK) (Entered: 04/01/2011)
04/01/2011		Pursuant to Local Rule 2.08, the assigned/referred magistrate

		judge is designated and authorized by the court to exercise full authority in this assigned/referred action or matter under 28 U.S.C. Sec. 636 and 18 U.S.C Sec. 3401. (CSAW) (Entered: 04/01/2011)
04/07/2011	7	ANSWER to Complaint by Group Health Plan, Inc.. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3)(Dee, Thomas) (Entered: 04/07/2011)
04/07/2011	8	MOTION for Judgment on the Pleadings by Defendant Group Health Plan, Inc. (Dee, Thomas) (Entered: 04/07/2011)
04/07/2011	9	MEMORANDUM in Support of Motion re 8 MOTION for Judgment on the Pleadings filed by Defendant Group Health Plan, Inc.. (Dee, Thomas) (Entered: 04/07/2011)
04/12/2011	10	MOTION for Extension of Time to File Response/Reply as to 8 MOTION for Judgment on the Pleadings by Plaintiff Jodie Nevils. (Campbell, John) (Entered: 04/12/2011)
04/13/2011	11	Docket Text ORDER: Re: 10 MOTION for Extension of Time up to and including April 25, 2011, to File Response/Reply as to 8 MOTION for Judgment on the Pleadings by Plaintiff Jodie

		Nevils. (Campbell, John); ORDERED GRANTED. Signed by Magistrate Judge David D. Noce on 4/13/11. (KXS) (Entered: 04/13/2011)
04/25/2011	13	RESPONSE to Motion re 8 MOTION for Judgment on the Pleadings filed by Plaintiff Jodie Nevils. (Campbell, John) (Entered: 04/25/2011)
04/27/2011	14	SCHEDULING ORDER: IT IS HEREBY ORDERED that the court will hear oral argument on defendant's motion for judgment on the pleadings (Doc. 8) at the May 19, 2011 scheduling conference. Signed by Magistrate Judge David D. Noce on 4/27/11. (KKS) (Entered: 04/27/2011)
04/27/2011	15	RULE 16 ORDER Joint Scheduling Plan due by 5/13/2011. Rule 16 Conference set for 5/19/2011 02:00 PM in Courtroom 17N before Magistrate Judge David D. Noce. Magistrate Consent due by 4/28/2011.. Signed by Magistrate Judge David D. Noce on 4/27/11. (KKS) (Entered: 04/27/2011)
04/27/2011		Receipt 4644021228 in the amount of $100.00 for PRO HAC VICE on behalf of Don P. Saxton (CCAM) (Entered: 04/28/2011)

04/27/2011		Receipt 4644021228 in the amount of $100.00 for PRO HAC VICE on behalf of Mitchell L. Burgess (CCAM) (Entered: 04/28/2011)
04/27/2011		Receipt 4644021228 in the amount of $100.00 for PRO HAC VICE on behalf of Ralph K. Phalen (CCAM) (Entered: 04/28/2011)
04/27/2011	16	MOTION for Leave to Appear Pro Hac Vice Mitchell L. Burgess (Filing fee $100) by Plaintiff Jodie Nevils. (DJO) (Entered: 04/28/2011)
04/27/2011	17	MOTION for Leave to Appear Pro Hac Vice Don P. Saxton (Filing fee $100) by Plaintiff Jodie Nevils. (DJO) (Entered: 04/28/2011)
04/27/2011	18	MOTION for Leave to Appear Pro Hac Vice Ralph K. Phalen (Filing fee $100) by Plaintiff Jodie Nevils. (DJO) (Entered: 04/28/2011)
04/27/2011	19	FULL CONSENT has been received by by Defendant Group Health Plan, Inc., Plaintiff Jodie Nevils. (DJO) (Entered: 04/28/2011)
05/02/2011	20	Docket Text ORDER Re: 18 MOTION for Leave to Appear Pro Hac Vice Ralph K. Phalen 17 MOTION for Leave to Appear Pro Hac Vice Don P. Saxton 16 MOTION for Leave to Appear Pro

		Hac Vice Mitchell L. Burgess; ORDERED GRANTED. Signed by Magistrate Judge David D. Noce on 5/2/2011. (KMS) (Entered: 05/02/2011)
05/02/2011		ORDER RECEIPT: (see receipt) Docket No: 20, sent to parties not set up for electronic notification Mon May 2 14:29:40 CDT 2011 (Scheele, Kara) (Entered: 05/02/2011)
05/02/2011	21	MOTION to Remand Case to State Court by Plaintiff Jodie Nevils. (Phalen, Ralph) (Entered: 05/02/2011)
05/04/2011	22	Joint MOTION to Stay *discovery pending court ruling on current motions* by Plaintiff Jodie Nevils. (Phalen, Ralph) (Entered: 05/04/2011)
05/05/2011	23	REPLY to Response to Motion re 8 MOTION for Judgment on the Pleadings filed by Defendant Group Health Plan, Inc.. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Dee, Thomas) (Entered: 05/05/2011)
05/09/2011	24	ORDER; IT IS HEREBY ORDERED that the joint motion of the parties to stay discovery pending resolution of the motion to remand and motion for judgment on the pleadings (Doc. 22) is sustained. IT IS

		FURTHER ORDERED that the court will hear oral argument on the motion to remand Thursday, May 19, 2011 at 2:30 p.m. in lieu of the Rule 16 conference. IT IS FURTHER ORDERED the order setting this case for a Rule 16 conference is vacated. Signed by Magistrate Judge David D. Noce on 05/09/2011. (DJO) (Entered: 05/09/2011)
05/09/2011		ORDER RECEIPT: (see receipt) Docket No: 24. to non–registered party Mon May 9 09:39:03 CDT 2011 (O'Leary, Deborah) (Entered: 05/09/2011)
05/12/2011	25	MEMORANDUM in Opposition re 21 MOTION to Remand Case to State Court filed by Defendant Group Health Plan, Inc.. (Dee, Thomas) (Entered: 05/12/2011)
05/17/2011	26	Consent MOTION to Continue oral argument by Plaintiff Jodie Nevils. (Phalen, Ralph) (Entered: 05/17/2011)
05/18/2011	27	ORDER IT IS HEREBY ORDERED that plaintiff's consent motion to continue oral arguments (Doc. 26) is sustained. Oral arguments on defendant's motion to remand are rescheduled for June 2, 2011 at 10:00 am. 26 Signed by Magistrate Judge David D. Noce on 5/18/11. (KXS)

		(Entered: 05/18/2011)
05/23/2011	28	REPLY IN SUPPORT OF MOTION 21 to Remand Case to State Court by Plaintiff Jodie Nevils. (Saxton, Don) Modified on 5/24/2011 (KKS). (Entered: 05/23/2011)
06/02/2011	29	Minute Entry for proceedings held before Magistrate Judge David D. Noce: Motion Hearing held on 6/2/2011 re 21 MOTION to Remand Case to State Court filed by Jodie Nevils; arguments heard; matter taken under submission. (FTR Gold Operator initials:K. Spurgeon.) (FTR Gold: Yes.) (KXS) (Entered: 06/02/2011)
06/06/2011	30	Supplemental to 21 MOTION to Remand Case to State Court *Supplemental Authority* by Defendant Group Health Plan, Inc.. (Dee, Thomas) Modified on 6/10/2011 (KMS). (Entered: 06/06/2011)
06/15/2011	31	MEMORANDUM AND ORDER OF REMAND; For the reasons set forth above, IT IS HEREBY ORDERED that the motion of plaintiff Jodie Nevils to remand (Doc. 21) is hereby sustained. The case is remanded to the Circuit Court of St. Louis County for further proceedings. IT IS FURTHER ORDERED that the

		motion of defendant Group Health Plan, Inc. for judgment on the pleadings (Doc. 8) is deferred to the Missouri circuit court. Signed by Magistrate Judge David D. Noce on 06/15/2011. (DJO) (Certified copy of order to St. Louis County Circuit Court, 7900 Carondelet, Clayton, MO 63105); (Entered: 06/15/2011)

ED98538 - JODIE NEVILS, APP V. GROUP HEALTH, ET AL., RES
Docket Entries

03/21/2013 **Disp-Tran W/ Opin SC- SC Ord**
CASE TRANSFERRED TO SUPREME COURT

03/19/2013 **Sustained**
Associated Entries: 02/13/2013 - Appl for Tran SC Filed in SC
Associated Entries: 02/13/2013 Appl for Tran SC Filed In SC

02/13/2013 **Note to Clerk eFiling**
Filed By: BLAKE PATRICK GREEN

Appl for Tran SC Filed in SC
Application for Transfer - Sup Ct; E D Opinion; Motion for Rehearing; Application for Transfer - ED; Notice Denying Transfer and Rehearing; Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 03/19/2013 - Sustained

Appl for Tran SC Filed in SC
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 03/19/2013 - Sustained

01/29/2013 **Denied**
Associated Entries: 01/09/2013 - Application for Transfer to SC
Associated Entries: 01/09/2013 - Motion for Rehearing

01/09/2013 **Application for Transfer to SC**
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 01/29/2013 - Denied

Motion for Rehearing
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 01/29/2013 – Denied

12/26/2012 **Clerk Remark**
VOTE
Opinion- Affirmed
Signed Majority Opinion

12/11/2012 **Case Submitted**
Scheduled For: 12/11/2012; DIVISION 1; EASTERN DISTRICT CT OF APPEALS

11/27/2012 **Paper Copy of Document Receivd**
Appellants Reply Brief

11/21/2012 **Granted**
Associated Entries: 11/20/2012 - Mot File BrfsLonger Rule Allow

Granted Until
November 21, 2012
Associated Entries: 11/20/2012 - Mot Ext Time File Reply Brf

11/20/2012 **Paper Copy of Document Due**
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Note to Clerk eFiling
Filed By: BLAKE PATRICK GREEN

Appellant's Reply Brief
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

Mot File BrfsLonger Rule Allow
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 11/21/2012 - Granted

Mot Ext Time File Reply Brf
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 11/21/2012 - Granted Until

10/31/2012 **Paper Copy of Document Receivd**
Amicus Curiae Brief

10/30/2012 **Granted Until**
November 19, 2012
Associated Entries: 10/29/2012 - Mot Ext Time File Reply Brf

Granted
Associated Entries: 10/25/2012 - Amicus Curiae Mot to File Brf

10/29/2012 **Suggestions in Opposition**
Sugg in Opp to Amicus Filing;
Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS
On Behalf Of; JODIE NEVILS
Associated Entries: 10/25/2012 -

Amicus Curiae Brief

Mot Ext Time File Reply Brf
Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS
On Behalf Of: JODIE NEVILS
Associated Entries: 10/30/2012 - Granted Until

Paper Copy of Document Receivd
Respondents Brief

10/25/2012 **Appendix Filed**
Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

Paper Copy of Document Due
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Respondent's Brief
Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

Paper Copy of Document Receivd
RESPONDENTS BRIEF

Appendix Filed
Electronic Filing Certificate of Service.
Filed By: WINTHROP BLACKSTONE REED III
On Behalf Of: ACS RECOVERY SERVICES, INC.

Paper Copy of Document Due
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Respondent's Brief
Electronic Filing Certificate of Service.
Filed By: WINTHROP BLACKSTONE REED III
On Behalf Of: ACS RECOVERY SERVICES, INC.

Paper Copy of Document Due
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Amicus Curiae Brief
Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
Associated Entries: 10/29/2012 - Suggestions in Opposition

Amicus Curiae Mot to File Brf
Filed By: NICHOLAS PATRICK LLEWELLYN
Associated Entries: 10/30/2012 - Granted

10/05/2012 **Case Docketed**
DIVISION 1: Ahrens, Clifford H., P.J.; Sullivan, Sherri B., J; Norton, Glenn A., J. December 11, 2012
Docket attached

09/21/2012 **Granted Until**
October 25, 2012
Associated Entries: 09/20/2012 - Mot for Ext Time to File Brief

09/20/2012 **Mot for Ext Time to File Brief**
Electronic Filing Certificate of Service.
Filed By: MELISSA Z. BARIS
On Behalf Of: GROUP HEALTH PLAN, INC., ACS RECOVERY SERVICES, INC.
Associated Entries: 09/21/2012 - Granted Until

Req for Oral Argument Filed
Respondent GHP Health Plan, Inc Request for Oral Argument; Electronic Filing Certificate of Service
Filed By: MELISSA Z. BARIS
On Behalf Of: GROUP HEALTH PLAN, INC.

Req for Oral Argument Filed
Request for Oral Argument; Electronic Filing Certificate of Service.
Filed By: STEVEN DAVID HALL
On Behalf Of: ACS RECOVERY SERVICES, INC.

09/13/2012 **Case Screened- Regular**
ORAL ARGUMENT LETTER ATTACHED

09/12/2012 **Paper Copy of Document Receivd**
Appellant Brief

09/10/2012 **Paper Copy of Document Due**
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Appellant's Brief
Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS

08/22/2012 **Granted Until**
September 10, 2012
Associated Entries: 08/22/2012 - Motion for Extension of Time

Motion for Extension of Time
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
Associated Entries: 08/22/2012 - Granted Until

08/09/2012 **Paper Copy of Document Due**
One paper copy of record due within five days. E.D. Rule 333 (c).

Supplemental Legal File
Supp Legal File; Electronic Filing

Certificate of Service.
Filed By: STEVEN DAVID HALL
On Behalf Of: ACS RECOVERY SERVICES, INC.

Paper Copy of Document Receivd
SUPPLEMENTAL LEGAL FILE AND INDEX OF RESPONDENT ACS RECOVERY SERVICES, INC.

07/05/2012 **Entry of Appearance Filed**
Electronic Filing Certificate of Service.
Filed By: WINTHROP BLACKSTONE REED III
On Behalf Of: ACS RECOVERY SERVICES, INC.

06/26/2012 **Paper Copy of Document Received**
7 VOLUMES OF LEGAL FILES

06/25/2012 **Paper Copy of Document Due**
One paper copy of record due within five days. E.D. Rule 333 (c).

Legal File/ROA Complete
Pl s Legal File and Index- Vol 1; Pl s Legal File and Index- Vol 2; Pl s Legal File and Index- Vol 3; Legal File and Index- Vol 4; Pl s Legal File and Index- Vol 5; Pl s Legal File and Index- Vol 6; Pl s File and Index- Vol 7; Electronic Filing Certificate of Service.
Filed By: STEPHANIE HING-YIN TO

On Behalf Of: JODIE NEVILS

06/11/2012	**Correspondence Sent** Efiling notice sent by mail to Don Saxton and Thomas Dee **Acknowledgement Letter Sent**
06/08/2012	**NOA Filed in Appellate Court**
05/29/2012	**Suppl Ntc Appl-Legal File Only** **Filing Fee Paid** **NOA Filed in Circuit Court**

SC93134 - JODIE NEVILS,APP V GROUP HEALTH PLAN,INC,ETAL,RES (E-CASE)
Docket Entries

08/05/2016 **Correspondence Received**
LETTER DATED AUGUST 2, 2016, RECEIVED FROM THE SUPREME COURT OF THE UNITED STATES

05/19/2016 **Case Disp- Opin & Mandate Sent**
CERTIFIED COPY OF OPINION AND MANDATE SENT TO THE CIRCUIT CLERK OF ST. LOUIS COUNTY. OPINION RELEASE SHEET MAILED TO CAROL MEHLE WITH THOMSON REUTERS.

05/03/2016 **Concurring Opinion**
Author of Opinion - Paul C. Wilson

Opinion Reversed & Remanded
FISCHER, STITH, DRAPER AND RUSSELL, JJ., CONCUR; WILSON, J., CONCURS IN RESULT SEPARATE OPINION FILED; BRECKENRIDGE, C.J., FISCHER, STITH, DRAPER AND RUSSELL, JJ., CONCUR IN OPINION OF WILSON, J. MOTIONS FOR REHEARING MUST BE FILED WITHIN 15 DAYS FROM THIS DATE (RULE 84.17). THE PROVISIONS OF RULE 44.01(E) DO NOT APPLY TO EXTEND THE TIME FOR FILING MOTIONS FOR REHEARING.

Signed Majority Opinion
Author of Opinion - Richard B. Teitelman

04/01/2016 **Correspondence Received**
Notice of Supplemental Authority; Exhibit A; Electronic Filing Certificate of Service.
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

12/15/2015 **Correspondence Received**
Letter - Cases Discussed During Argument That Were Not Cited in Briefs; Electronic Filing Certificate of Service.
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

12/10/2015 **Case Submitted**
ARGUED AND SUBMITTED.
Scheduled For: 12/10/2015; ; SUPREME COURT OF MISSOURI; Setting: 5; SUPREME COURT OF MISSOURI

11/30/2015 **Appellant's Reply Brief**
Appellant's Reply Brief; Electronic Filing Certificate of Service.
Filed By: JOHN ERIC CAMPBELL
On Behalf Of: JODIE NEVILS

11/25/2015 Notice
Letter re: oral argument; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA

11/23/2015 Sustained Until
ORDER ISSUED: APPELLANT'S MOTION FOR EXTENSION OF TIME TO FILE REPLY BRIEF REMAND SUSTAINED. APPELLANT'S REPLY BRIEF IS NOW DUE ON OR BEFORE NOVEMBER 30, 2015.
Associated Entries: 11/22/2015 - Mot Ext Time File Reply Brf

11/22/2015 Mot Ext Time File Reply Brf
APPELLANT'S MOTION FOR EXTENSION OF ONE BUSINESS DAY TO FILE APPELLANT'S REPLY BRIEF, TO NOVEMBER 30, 2015; Electronic Filing Certificate of Service.
Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS
Associated Entries: 11/23/2015 - Sustained Until

11/16/2015 Filing
Letter regarding position of parties on the filing of amicus brief; Electronic Filing Certificate of Service.

Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA

Amicus Curiae Brief
Amicus Curiae Brief of the United States in Support of Respondent; Electronic Filing Certificate of Service. THIS BRIEF WAS FILED WITH THE CONSENT OF THE PARTIES.
Filed By: NICHOLAS PATRICK LLEWELLYN

Respondent's Brief
RESPONDENT'S BRIEF ON REMAND; APPENDIX TO RESPONDENT S BRIEF ON REMAND Cover to A 62; APPENDIX TO RESPONDENTS BRIEF ON REMAND A 63 TO A 100; APPENDIX TO RESPONDENTS BRIEF ON REMAND A 101 TO A 177; APPENDIX TO RESPONDENTS BRIEF REMAND A 178 TO A 371; APPENDIX TO RESPONDENTS BRIEF ON REMAND A 372 TO A 541 END; Electronic Filing Certificate of Service.
Filed By: DAVID M EISENBERG
On Behalf Of: GROUP HEALTH PLAN, INC., ACS RECOVERY SERVICES, INC.

10/22/2015 Case Docketed

CAUSE DOCKETED FOR ORAL ARGUMENT ON DECEMBER 10, 2015. PLEASE SEE ATTACHED DOCKET LETTER, DOCKET, AND NOTICES TO COUNSEL.

Sustained
ORDER ISSUED:RESPONDENTS' UNOPPOSED MOTION TO RESCHEDULE ORAL ARGUMENT DOCKET SUSTAINED. CAUSE REMOVED FROM THE ORAL ARGUMENT DOCKET FOR DECEMBER 1, 2015. CAUSE ORDERED DOCKETED FOR ORAL ARGUMENT ON DECEMBER 10, 2015.

Associated Entries: 10/22/2015 - Mot Reschedule Case on Docket

Mot Reschedule Case on Docket
RESPONDENT'S UNOPPOSED MOTION TO RESCHEDULE ORAL ARGUMENT; EXHIBIT A; Electronic Filing Certificate of Service.

Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.
Associated Entries: 10/22/2015 - Sustained

Sustained
ORDER ISSUED: RULE 9.03 VISITING ATTORNEY STATUS

GRANTED TO ATTORNEY MIGUEL A. ESTRADA. THE E-FILING SYSTEM WILL NOT SERVE OUT OF STATE COUNSEL. LOCAL COUNSEL IS RESPONSIBLE FOR ADVISING OUT OF STATE COUNSEL OF ALL FILINGS AND RULINGS.

Associated Entries: 10/21/2015 - Motion for Pro Hac Vice

Sustained
ORDER ISSUED: RULE 9.03 VISITING ATTORNEY STATUS GRANTED TO ATTORNEY JONATHAN C. BOND. THE E-FILING SYSTEM WILL NOT SERVE OUT OF STATE COUNSEL. LOCAL COUNSEL IS RESPONSIBLE FOR NOTIFIYING OUT OF STATE COUNSEL OF ALL FILINGS AND RULINGS.

Associated Entries: 10/21/2015 - Motion for Pro Hac Vice

10/21/2015 **Motion for Pro Hac Vice**
RESPONDENT'S MOTION FOR PRO HAC VICE ADMISSION OF JONATHAN C. BOND; Exhibit A; Exhibit B; Electronic Filing Certificate of Service.

Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

Associated Entries: 10/22/2015 - Sustained

Motion for Pro Hac Vice
RESPONDENT'S MOTION FOR PRO HAC VICE ADMISSION OF MIGUEL A. ESTRADA; Exhibit A; Exhibit B; Electronic Filing Certificate of Service.
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.
Associated Entries: 10/22/2015 – Sustained

Entry of Appearance Filed
ENTRY OF APPEARANCE; Electronic Filing Certificate of Service.
Filed By: DAVID M EISENBERG
On Behalf Of: GROUP HEALTH PLAN, INC.

10/20/2015 **Clerk Remark**
CAUSE DOCKETED FOR ORAL ARGUMENT ON DECEMBER 1, 2015. PLEASE SEE ATTACHED DOCKET LETTER, DOCKET, AND NOTICES TO COUNSEL.

10/06/2015 **Sustained**
ORDER ISSUED: APPELLANT'S MOTION FOR LEAVE TO FILE BRIEF AND APPENDIX ON REMAND ONE DAY OUT OF TIME SUSTAINED. SAID BRIEF AND APPENDIX ARE DUE ON THIS DATE.
Associated Entries: 10/06/2015 - Mot to File Brief Out of Time

Appellant's Brief
APPELLANT'S BRIEF ON REMAND; APPELLANT'S APPENDIX ON REMAND; Electronic Filing Certificate of Service.
Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS

Mot to File Brief Out of Time
Motion for Leave to File Appellant's Brief and Appendix One Day Out of Time; Electronic Filing Certificate of Service.
Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS
Associated Entries: 10/06/2015 - Sustained

09/04/2015 **Sustained**
ORDER ISSUED: APPELLANT'S AMENDED UNOPPOSED MOTION TO REVISE BRIEFING SCHEDULE SUSTAINED. APPELLANT'S BRIEF ON REMAND IS DUE ON OR BEFORE OCTOBER 5, 2015. RESPONDENTS' BRIEF ON REMAND IS DUE ON OR BEFORE NOVEMBER 16, 2015. APPELLANT'S REPLY BRIEF ON REMAND, IF ANY, IS DUE TEN DAYS THEREAFTER. FURTHER EXTENSION REQUESTS WILL NOT BE VIEWED WITH FAVOR. NOTE TO

COUNSEL FROM THE CLERK'S OFFICE: ORAL ARGUMENT DATES FOR DECEMBER 2015, ARE DECEMBER 1, 2015, DECEMBER 2, 2015, DECEMBER 9, 2015, AND DECEMBER 10, 2015

Associated Entries: 09/03/2015 - Mot Ext Time to File Brief

Overruled
ORDER ISSUED: APPELLANT'S UNOPPOSED MOTION FOR ADDITIONAL TIME TO FILE APPELLANT'S BRIEF OVERRULED AS MOOT.

Associated Entries: 09/03/2015 - Mot Ext Time to File Brief

09/03/2015 **Mot Ext Time to File Brief**
Amended Unopposed Motion to Revise Briefing Schedule; Electronic Filing Certificate of Service.

Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS
Associated Entries: 09/04/2015 - Sustained

Mot Ext Time to File Brief
Appellant's Unopposed Motion for Additional Time to File Appellant's Brief to October 5, 2015; Electronic Filing Certificate of Service.

Filed By: ERICH VINCENT

VIETH
On Behalf Of: JODIE NEVILS
Associated Entries: 09/04/2015 - Overruled

08/31/2015 **Correspondence Received**
MANDATE DATED FEBRUARY 4, 2014, RETURNED TO THIS OFFICE BY THE CIRCUIT CLERK ST. LOUIS COUNTY.

08/18/2015 **Court Order Issued**
ORDER ISSUED: APPELLANT SHALL FILE THE FIRST AND LAST BRIEF IN THIS CAUSE.

08/14/2015 **Court Order Issued**
ORDER ISSUED: IN LIGHT OF THE MANDATE OF THE SUPREME COURT OF THE UNITED STATES DATED JUNE 29, 2015, THE OPINION ISSUED IN THIS CAUSE ON FEBRUARY 4, 2015, IS VACATED AND THE MANDATE ISSUED ON FEBRUARY 21 , 2015, SENT TO THE CIRCUIT CLERK OF ST. LOUIS COUNTY IS HEREBY RECALLED. THE PARTIES SHALL FILE BRIEFS PURSUANT TO THE BRIEFING SCHEDULE SET FORTH IN SUPREME COURT RULE 84.24(l). LETTER SENT TO THE ST. LOUIS COUNTY CIRCUIT CLERK REQUESTING RETURN OF THE MANDATE AND ADVISING CAROL

MEHLE WITH THOMSON REUTERS OF THE ORDER.

08/06/2015 **Correspondence Received**
Letter to Clerk Requesting Additional Briefing/Argument; Electronic Filing Certificate of Service.
Filed By: JOHN ERIC CAMPBELL
On Behalf Of: JODIE NEVILS

08/05/2015 **Filing**
MANDATE AND SUMMARY DISPOSITION OF THE SUPREME COURT OF THE UNITED STATES FILED.

07/27/2015 **Note to Clerk eFiling**
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

Filing
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

07/06/2015 **Correspondence Received**
LETTER DATED JUNE 29, 2015, FROM THE SUPREME COURT OF THE UNITED STATES RECEIVED ADVISING THAT THE PETITION FOR WRIT OF CERTIORARI WAS GRANTED AND THE JUDGMENT IS VACATED AND REMANDED TO THE

SUPREME COURT OF MISSOURI FOR FURTHER CONSIDERATION IN LIGHT OF NEW REGULATIONS. THE MANDATE OF THE SUPREME COURT OF THE UNITED STATES WILL ISSUE NO EARLIER THAN 25 DAYS FROM JUNE 29, 2015.

05/05/2014 **Correspondence Received**
LETTER DATED APRIL 28, 2014, FROM THE SUPREME COURT OF THE UNITED STATES RECEIVED.

02/21/2014 **Filing**
CERTIFIED COPY OF OPINION AND MANDATE SENT TO THE CIRCUIT CLERK OF ST. LOUIS COUNTY. OPINION RELEASE SHEET FAXED AND MAILED TO CAROL MEHLE WITH THOMSON REUTERS

02/04/2014 **Concurring Opinion**
Author of Opinion - Paul C. Wilson

Opinion Reversed & Remanded
RUSSELL, C.J ., FISCHER, STITH AND DRAPER, JJ., CONCUR; WILSON, J., CONCURS IN SEPARATE OPINION FILED; BRECKENRIDGE, J., CONCURS IN OPINION OF WILSON, J. MOTIONS FOR REHEARING MUST BE FILED WITHIN 15 DAYS FROM THIS DATE (RULE 84.17). THE PROVISIONS OF

RULE 44.01(E) DO NOT APPLY TO EXTEND THE TIME FOR FILING MOTIONS FOR REHEARING.

Signed Majority Opinion
Author of Opinion - Richard B. Teitelman

09/12/2013 **Case Submitted**
ARGUED AND SUBMITTED.
Scheduled For: 09/12/2013; ; SUPREME COURT OF MISSOURI; Setting: 3; SUPREME COURT OF MISSOURI

09/10/2013 **Filing**
Letter to Court re Kobold v Aetna; Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

08/09/2013 **Sustained**
ORDER ISSUED: RULE 9.03 VISITING ATTORNEY STATUS GRANTED TO HENRY C. WHITAKER. NOTE: LOCAL COUNSEL MUST ADVISE OUT OF STATE COUNSEL OF ALL FILINGS, ORDERS OR RULINGS AS THE E-FILING SYSTEM CURRENTLY CANNOT SERVE OUT OF STATE COUNSEL.
Associated Entries: 08/08/2013 -

Motion for Pro Hac Vice

08/08/2013 **Motion for Pro Hac Vice**
Motion for admission pro hac vice; Affidavit; Fee receipt; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA
Associated Entries: 08/09/2013 - Sustained

07/24/2013 **Sustained**
ORDER ISSUED:AMICUS CURIAE UNITED STATES OF AMERICA'S UNOPPOSED MOTION TO PARTICIPATE IN ORAL ARGUMENT SUSTAINED. AMICUS CURIAE SHALL SHARE TIME FOR ARGUMENT WITH RESPONDENTS.
Associated Entries: 07/22/2013 - Motion for Oral Argument

07/22/2013 **Motion for Oral Argument**
Unopposed Motion for Leave to Participate in Oral Argument; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA
Associated Entries: 07/24/2013 – Sustained

07/15/2013 **Case Docketed**
CAUSE DOCKETED FOR ORAL ARGUMENT ON SEPTEMBER 12, 2013. PLEASE SEE ATTACHED DOCKET LETTER, DOCKET AND NOTICES TO COUNSEL.

06/17/2013 **Substitute Reply Brief**
of Appellant filed with service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

06/07/2013 **Note to Clerk eFiling**
Filed By: NICHOLAS PATRICK LLEWELLYN

Filing
Corrected letter regarding supplemental authority; Supreme Court opinion; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA

06/05/2013 **Filing**
Correspondence to Clerk Under Rule 84 20; Opinion of U S Supreme Court Hillman v Maretta; Electronic Filing Certificate of Service.
Filed By: CHRISTOPHER OWEN BAUMAN

On Behalf Of: ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS

05/30/2013 **Sustained Until**
ORDER ISSUED: APPELLANT'S MOTION FOR EXTENSION OF TIME TO FILE SUBSTITUTE REPLY BRIEF SUSTAINED. APPELLANT'S SUBSTITUTE REPLY BRIEF IS NOW DUE ON OR BEFORE JUNE 17, 2013.
Associated Entries: 05/29/2013 - Mot Ext Time File Reply Brf

05/29/2013 **Mot Ext Time File Reply Brf**
Motion for Extension of Time to File Reply; Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 05/30/2013 - Sustained Until

05/23/2013 **Note to Clerk eFiling**
Filed By: MARK G. ARNOLD.

Substitute Respondent's Brief
Substitute Brief of Respondents GHP and ACS; Electronic Filing Certificate of Service. RESPONDENT'S SUBSTITUTE BRIEF AND APPENDIX
Filed By: MARK G. ARNOLD
On Behalf Of: GROUP HEALTH

PLAN, INC., ACS RECOVERY SERVICES, INC.

Amicus Curiae Brief
Amicus Curiae Brief of the United States in Support of Respondents; Appendix to Amicus Curiae the United States; Electronic Filing Certificate of Service. ORDERED FILED "AS IS" ON THIS DATE. SEE RULE 81.18
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA

Amicus Curiae Brief
Brief of Amicus Curiae Association of Federal Health Organizations; Electronic Filing Certificate of Service.
Filed By: CHRISTOPHER OWEN BAUMAN
On Behalf Of: ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS

Sustained
ORDER ISSUED: RULE 9.03 VISITING ATTORNEY STATUS GRANTED TO DAVID ERMER AS CO-COUNSEL FOR AMICUS CURIAE THE ASSOCATION OF FEDERAL HEALTH ORGANIZATIONS. LOCAL COUNSEL IS REQUIRED TO ADVISE MR. ERMER OF ALL FILINGS AND

RULINGS AS MR. ERMER WILL NOT BE SERVED VIA THE E-FILING SYSTEM AT THIS TIME.

Associated Entries: 05/22/2013 - Motion for Pro Hac Vice

05/22/2013 **Motion for Pro Hac Vice**

Motion for Admission of Visiting Attorney to Appear in this Matter; Application to Appear Pro Hac Electronic Filing Certificate of Service.

Filed By: CHRISTOPHER OWEN BAUMAN

On Behalf Of: ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS

Associated Entries: 05/23/2013 - Sustained

Sustained

ORDER ISSUED: THE MOTION OF THE ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS SUSTAINED.

Associated Entries: 05/22/2013 - Amicus Curiae Mot to File Brf

Amicus Curiae Mot to File Brf

Filed By: CHRISTOPHER OWEN BAUMAN

On Behalf Of: ASSOCIATION OF FEDERAL HEALTH

ORGANIZATIONS
Associated Entries: 05/22/2013 - Sustained

Sustained
ORDER ISSUED: ATTORNEY STEPHANIE H. TO'S MOTION TO WITHDRAW AS COUNSEL FOR APPELLANT SUSTAINED.
Associated Entries: 05/22/2013 - Mot for Withdrawal of Counsel

Mot for Withdrawal of Counsel
Motion to Withdraw; Electronic Filing Certificate of Service.
Filed By: STEPHANIE HING-YIN TO
Associated Entries: 05/22/2013 – Sustained

05/16/2013 **Sustained**
ORDER ISSUED: THE MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF OF THE UNITED STATES OF AMERICA SUSTAINED.
Associated Entries: 05/16/2013 - Amicus Curiae Mot to File Brf

Entry of Appearance Filed
Entry of Appearance; Electronic Filing Certificate of Service.
Filed By: MARK G. ARNOLD
On Behalf Of: GROUP HEALTH PLAN, INC.

Amicus Curiae Mot to File Brf
Motion for leave to file amicus curiae brief; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
Associated Entries: 05/16/2013 - Sustained

Notice
Notice of Change of Address; Electronic Filing Certificate of Service. NOTICE OF CHANGE OF ADDRESS FOR ATTORNEYS ERICH VIETH AND JOHN CAMPBELL FILED WITH SERVICE.
Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS

Entry of Appearance Filed
Filed By: STEPHANIE HING-YIN TO
On Behalf Of: JODIE NEVILS

05/02/2013 **Sustained Until**
ORDER ISSUED: RESPONDENTS' MOTION FOR EXTENSION OF TIME TO FILE SUBSTITUTE BRIEFS SUSTAINED. RESPONDENTS' SUBSTITUTE BRIEFS ARE DUE ON OR BEFORE MAY 23, 2013.
Associated Entries: 05/02/2013 - Mot Ext Time to File Brief

Mot Ext Time to File Brief
Unopposed joint motion to extend the time to file brief; Electronic Filing Certificate of Service.
Filed By: STEVEN DAVID HALL
Associated Entries: 05/02/2013 - Sustained Until

04/19/2013 **Substitute Appellant's Brief**
Appellant's Substitute Brief and Appendix to Appellant Substitute Brief filed with service. Electronic Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

04/05/2013 **Sustained Until**
ORDER ISSUED: APPELLANT'S MOTION FOR EXTENSION OF TIME TO FILE APPELLANT'S SUBSTITUTE BRIEF SUSTAINED. APPELLANT'S SUBSTITUTE BRIEF IS NOW DUE ON OR BEFORE APRIL 19, 2013.
Associated Entries: 04/04/2013 - Mot Ext Time to File Brief

04/04/2013 **Mot Ext Time to File Brief**
Motion for Extension of Time for Appellant's Brief filed with service. Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS
On Behalf Of: JODIE NEVILS

Associated Entries: 04/05/2013 - Sustained Until

03/21/2013 **Record on Appeal Transferred**
CLERK, MISSOURI COURT OF APPEALS, EASTERN DISTRICT, FILED THE ENTIRE FILE HEREIN IN ACCORDANCE WITH THE ORDER OF THIS COURT DATED MARCH 19, 2013. THE FILE CONSISTS OF THE NOTICE OF APPEAL, RECORD ON APPEAL (SEVEN VOLUMES OF LEGAL FILE), APPELLANT'S BRIEF, AMICUS CURIAE BRIEF OF U.S., RESPONDENT ACS RECOVERY SERVICES, INC.'S BRIEF, RESPONDENT GROUP HEALTH PLAN, INC.'S BRIEF, APPELLANT'S REPLY BRIEF, AND CASE RELATED DOCUMENTS.

03/19/2013 **App Sustnd/Cause Ordered Tran**
APPELLANT'S APPLICATION FOR TRANSFER FROM THE MISSOURI COURT OF APPEALS, EASTERN DISTRICT, SUSTAINED AND CAUSE ORDERED TRANSFERRED. MANDATE SENT TO CLERK, MISSOURI COURT OF APPEALS, EASTERN DISTRICT, VIA E-MAIL AND TO ALL COUNSEL OF RECORD VIA THE MISSOURI EFILING SYSTEM. COUNSEL OF RECORD MAY WISH TO REVIEW RULE 83.08.
Associated Entries: 02/13/2013 -

Appl for Tran SC Filed in SC

02/22/2013 **Filing**
Letter with Supplemental Authority; Calingo 11 CV628 Order and Judgment; Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

02/20/2013 **Suggestions in Opposition**
Respondent s Opposition to Application for Transfer.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

02/19/2013 **Sustained**
ORDER ISSUED: RESPONDENT GROUP HEALTH PLAN INC.'S MOTION FOR LEAVE TO FILE SUGGESTIONS IN OPPOSITION SUSTAINED. SAID SUGGESTIONS IN OPPOSITION ARE DUE ON OR BEFORE FEBRUARY 20, 2013.
Associated Entries: 02/19/2013 - Other Motion

Other Motion
Motion for Leave to File Opposition to Application for Transfer; Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH

PLAN, INC.
Associated Entries: 02/19/2013 – Sustained

02/13/2013 **Filing Fee Paid**
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

Filing Info Sheet eFiling
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

Appl for Tran SC Filed in SC
Appellant's Application for Transfer from the Missouri Court of Appeals, Eastern District; ED Opinion; Motion for Rehearing Filed in ED; Application for Transfer Flied in ED; Notice Denying Rehearing and Transfer.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 03/19/2013 - App Sustnd/Cause Ordered Tran

Transfer Summary - Form 15
Form 15 - Cover Page to Application for Transfer
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

CLASS ACTION PETITION FOR DAMAGES
(Mo. Cir. Ct. Feb. 14, 2011)

Plaintiff, Jodie Nevils, on behalf of himself and all others similarly situated, alleges and avers the following for this class action against Defendant:

INTRODUCTION AND BACKGROUND

1. This action is brought by the Plaintiff on behalf of himself and others similarly situated regarding the Defendant's practice of asserting liens and/or rights of reimbursement against the personal injury settlements of Plaintiff and the Class Members when the Defendant has no legal right to assert said liens.

2. Defendant Group Health Plan, Inc. ("Group Health Plan") is a private corporate entity that contracts to provide health insurance to individual persons.

3. Upon information and belief, Group Health Plan contracts with the Federal government, through the Office of Personnel Management as a "carrier" to administer healthcare benefits in accordance with the provisions of the Federal Employee Health Benefits Act (FEHBA). 5 U.S.C. § 8901 *et. seq*.

4. FEHBA is a comprehensive statutory and regulatory scheme that provides federal employees, federal retirees, and their eligible family members with subsidized healthcare benefits.

5. The Defendant routinely engages in a widespread pattern and practice of unlawfully asserting reimbursement rights on healthcare benefits that are paid pursuant to health plans subject to the provisions of FEHBA.

6. For instance, occasionally an individual is injured in an auto accident and that individual's health care benefits are covered through a FEHBA plan. If that individual pursues legal action against the tortfeasor for his/her injuries, the Defendant unlawfully assert a lien for repayment of the health care benefits paid for such treatment.

7. Absent a Federal provision that affords lien/subrogation rights to an FEHBA "carrier" such as Group Health Plan, such rights, if they exist, are wholly derivative of state law.

8. There is no Federal provision that provides lien and/or subrogation rights to reimbursement for benefits paid by a FEHBA "carrier" such as Defendant Group Health Plan.

9. Under Missouri law, subrogation on personal injury claims is prohibited. Accordingly, since Missouri law controls whatever reimbursement rights to which the Defendant would be entitled, Defendant has no right of reimbursement for benefits paid pursuant to a FEHBA health plan.

10. Despite the fact that any reimbursement/subrogation rights are controlled by Missouri state law that prohibits such subrogation, Defendant routinely asserts liens on personal injury recoveries of Missouri citizens and subrogate for repayment of health benefits paid out on personal injury claims of Missouri citizens.

11. Defendant pursues such course of conduct despite being informed repeatedly that they are not entitled to reimbursement of such funds under Missouri law.

12. By employing such a policy and business model, Defendant has unlawfully violated the rights

of Plaintiff and the Class members as described more particularly below.

13. Further, such conduct of the Defendant, and their agents, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the rights of Plaintiff and the Class members such that punitive damages are appropriate and warranted.

JURISDICTION AND VENUE

14. This Court has personal jurisdiction over Defendant Group Health Plain since the Defendant transacted business in Missouri, violated the law within the State of Missouri, and otherwise has sufficient minimum contacts with the state of Missouri as more particularly described below. Defendant Group Health Plan has sufficient minimum contacts, and in fact, substantial contacts with Missouri such that the maintenance of this suit does not offend traditional notions of fair play and substantial justice. Defendant has voluntarily submitted itself to the jurisdiction of this Court and jurisdiction is proper because, among other things:

a. Defendant committed tortious acts within this state;

b. Plaintiffs' and the Class members' causes of action directly arise from the commission of tortious and unlawful acts in Missouri by Defendant:

c. Plaintiffs' and the Class members' causes of action directly arise from Defendant's transaction(s) of business in Missouri;

d. Defendant should reasonably anticipate being haled into court in Missouri to answer for its unlawful acts. Missouri has a strong interest in providing a forum for its residents aggrieved by violations of the law.

15. Venue is proper in this Circuit pursuant to RSMo § 508.010 in that a substantial part of the events giving rise to the claim occurred in within this Circuit.

PARTIES

Plaintiff

16. Plaintiff Jodie Nevils currently resides in Saint Louis County, Missouri.

Defendant

17. Defendant Group Health Plan is a private health insurance provider. Group Health Plan is organized under the laws of Missouri and is authorized to do business in the Sate of Missouri.

ALLEGATIONS COMMON TO ALL COUNTS

18. On or about November 2, 2006, representative Plaintiff Jodie Nevils was injured in a motor vehicle accident.

19. Plaintiff Nevils received treatment for his injuries sustained in the accident from numerous healthcare providers.

20. Plaintiff Nevils asserted a personal injury claim against the driver tortfeasor for his injuries sustained in the November 2, 2006 accident.

21. Plaintiff Nevils reached a settlement with the tortfeasor, paid through the tortfeasor's auto in-

surance policy, in compensation for his injuries, medical treatment, and pain and suffering, sustained in the accident.

22. Plaintiff Nevils was entitled to medical insurance coverage through a federal health benefit plan. The health plan that covers Plaintiff is governed by the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914 ("FEHBA").

23. The federal government has contracted with Defendant Group Health Plan to act as a "carrier" under FEHBA to provide health benefits and administer the subsidized healthcare plan provided under FEHBA to enrollees such as Ms. Nevils.

24. Plaintiff Nevils' medical bills related to the auto accident were paid by Defendant Group Health Plan.

25. Defendant Group Health Plan unlawfully asserted a lien in the amount of $6,592.24 for healthcare benefits and services provided to Mr. Nevils in treatment of his accident related injuries.

26. The United States Supreme Court held in *Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677 (2006) that FEHBA's preemption clause — 5 U.S.C. § 8902(m)(1) — does not apply to subrogation or reimbursement rights of an insurer. Therefore, Missouri state law applies to the reimbursement rights of an insurer.

27. Missouri law has long prohibited subrogation in personal injury claims and does not allow for reimbursement to health insurers for payments made for treatment received related to a personal injury. This prohibition on subrogation of personal injury claims exists even if there is a contractual provision

in the health benefit plan that purports to allow for such subrogation rights.

28. There is no Federal provision that provides a reimbursement/subrogation right to such medical benefits paid pursuant to a FEHBA plan. Accordingly, such reimbursement rights are controlled by Missouri law, which expressly prohibits subrogation of health care benefits paid in connection with personal injury settlements.

29. Upon information and belief, despite being aware and informed of their lack of entitlement to reimbursement, the Defendant continued to pursue payment of unlawful reimbursement from Plaintiff's personal injury settlement.

30. On or about, January 29, 2010, Mr. Nevils remitted $6,592.24 to Defendant by and through Defendant's agent, ACS Recovery.

31. Subsequently, Defendant converted the funds from Mr. Nevils' personal injury settlement.

CLASS ACTION ALLEGATIONS

32. This action is brought as a plaintiff class pursuant to Missouri Rule of Civil Procedure 52.08. Plaintiff brings this action on her own behalf and all others similarly situated, as representative of the following class.

> All Missouri residents who received health insurance coverage through a FEHBA plan, administered by Defendant Group Health Plan Inc., who have had a right of reimbursement asserted against a personal injury claim or settlement by Group Health Plan and/or its agents, contractors or other third parties acting on its behalf, and such reim-

bursement was paid to Defendant since within five years of the filing date of this Petition.

33. The particular members of the class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of the Defendant. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

34. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class members. The only material difference between the Class members' claims is the exact monetary amount to which each member of the Class is entitled. The principal common issues include, but are certainly not limited to the following:

(a) Whether Group Health Plan entered into express and/or implied agreements with the federal government providing for reimbursement/subrogation rights on personal injury claims;

(b) Whether a provision for reimbursement/subrogation rights on personal injury claims contained in such a statement of benefits would be unenforceable under Missouri law;

(c) Whether Defendant employs a policy and business model of unlawfully asserting reimburse-

ment/subrogation rights to which they are not entitled;

(d) Whether Defendant unlawfully asserted reimbursement/subrogation rights against personal injury claims/settlements in violation of Missouri law;

(e) Whether the Defendant utilized aggressive collection practices to collect reimbursement of funds from the Plaintiff and the Class to which they were not entitled under applicable law;

(f) Whether such uniform practices asserted against all class members were unlawful and, thereby, unjustly profited the Defendant at the Plaintiff's and the Class members' expense;

(g) Whether Defendant has been unjustly enriched at the Plaintiff's and the Class members' expense through the misconduct described herein;

(i) Whether Defendant violated the Missouri Merchandising Practices Act through the above described misconduct;

(k) Whether Defendant should be enjoined from continuing their unfair, predatory, and abusive conduct

35. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories.

36. Plaintiff will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel in complex class actions. Counsel is committed to the vigorous prosecution of this action.

37. Certification of a plaintiff class is appropriate in that Plaintiff and the Class members seek monetary damages, common questions predominate over any individual questions, and a plaintiff class action is superior for the fair and efficient adjudication of this controversy. A plaintiff class action will cause an orderly and expeditious administration of the Class members' claims and economies of time, effort and expense will be fostered and uniformity of decisions will be ensured. Moreover, the individual class members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against the likes of the Defendant.

38. Alternatively, certification of a plaintiff class is appropriate in that inconsistent or varying adjudications with respect to individual members of the Class would establish incompatible standards of conduct for the Defendant or adjudications with respect to individual members of the Class as a practical matter would be dispositive of the interests of the other members not parties to the adjudications or would substantially impair or impede their ability to protect their interests.

39. Defendant has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole.

COUNT I
(Violation of the Missouri Merchandising Practices Act)

40. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

41. RSMo. § 407.020 prohibits the use of any "deception, fraud, false pretense, false promise, misrepresentation, unfair practice or the concealment, suppression, or omission of any material fact in connection with the sale or advertisement of any merchandise in trade or commerce..."

42. An "unfair practice" is defined by Missouri law, 15 CSR 60-8.020, as any practice which:

(A) Either-

1. Offends any public policy as it has been established by the Constitution, statutes or common law of this state, or by the Federal Trade Commission, or its interpretive decisions; or

2. Is unethical, oppressive or unscrupulous; and

(B) Presents a risk of or causes, substantial injury to consumers.

43. An "unfair practice" is further defined by Missouri law, 15 CSR 60-8.040, accordingly:

(l) It is an unfair practice for any person in connection with the advertisement or sale of merchandise to violate the duty of good faith in solicitation, negotiation and performance, or in any manner fail to act in good faith.

44. "Merchandise" is defined by the MPA, at RSMo. § 407.010(4), to include the providing of "services" and, therefore, encompasses the providing for the administration of medical care and billing for the same:

45. "Person" is defined by the MPA, at RSMo. § 407.010(5), to include any "for-profit or not-for-

profit corporation...company...business entity or association, and any agent, employee, salesman, partner, officer, director, member, stockholder, associate, trustee or cestui que trust thereof."

46. The above described behavior, misconduct, and unlawful acts of the Defendant violate the Missouri Merchandising Practices Act by, among other things, constituting an unfair practice and breach of the duty of good faith as required under the Act.

47. As a result of the above described wrongful acts, Plaintiff and the Class members have suffered damages.

COUNT II
(Unjust Enrichment)

48. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

49. As alleged above, the Defendant has engaged in a pattern and practice of unlawfully subverting the financial interests of Plaintiff and the Class for their own pecuniary gain.

50. Defendant has been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled to and received in violation of Missouri law.

51. Said benefits were unlawfully obtained to the detriment of Plaintiff and the Class Members.

52. Allowing Defendant to retain the aforementioned benefits violates fundamental principles of justice, equity, and good conscience.

COUNT III
(Conversion)

53. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

54. As alleged above, Defendant has engaged in a pattern and practice of unlawfully depriving the Plaintiff and the Class of certain property.

55. Plaintiff and the Class were legally entitled to the property in question when the Defendant deprived Plaintiff of the property.

56. Defendant acted purposefully and wrongfully in dispossessing Plaintiff and the Class of the property in question.

57. Such unfair misconduct by Defendant caused economic injury and other damages to the Plaintiff and the Class.

COUNT IV
(Injunctive Relief)

58. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

59. As set forth herein, Defendant has improperly taken the property of Plaintiff and the Class Members for its own pecuniary benefit as prohibited by law.

60. Upon information and belief, Defendant continue the unlawful practices enumerated above causing irreparable harm to the Plaintiff and the Class members.

61. As set forth herein, Plaintiff and the Class have a high probability of success on the merits of this action.

62. Accordingly, Defendant should be enjoined from continuing to perpetuate such predatory and unfair practices on consumers, such as Plaintiff and the Class.

PRAYER FOR DAMAGES AND RELIEF

WHEREFORE, Plaintiff, on behalf of himself and all members of the Class respectfully prays for judgment against the Defendant as follows:

a) For an order certifying that this action may be maintained as a class action and appointing Plaintiff and his counsel, to represent the Class;

b) For a declaration that the Defendant's actions violated the Plaintiff's and the Class members' rights under Missouri law as plead herein;

c) For all actual damages, punitive damages, statutory damages, penalties, and remedies available for the Defendant's violations of Plaintiff's and the Class members' rights under Missouri law;

d) For a declaration that Defendant, through the actions and misconduct as alleged above, have been unjustly enriched and an order that Defendant disgorge any unlawfully gained proceeds;

e) For pre-judgment interest as provided by law;

f) For post-judgment interest as provided by law;

g) For a permanent injunction enjoining Defendant from engaging in the unlawful practices as enumerated above;

h) For an award to Plaintiff and the Class their reasonable attorneys' fees;

i) For an award to Plaintiff and the Class of their costs and expenses of this action;

j) For such other and further relief as the Court may deem necessary and proper.

Respectfully Submitted,

By: s/_____

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ATTORNEYS FOR PLAINTIFFS

AFFIDAVIT OF DAVID DICKSON
(Mo. Cir. Ct. Aug. 16, 2011)

I, David Dickson, declare as follows:

1. I am over the age of 18 years and competent to testify to the following facts, based upon my personal knowledge and knowledge gathered in the course of my employment.

2. I am employed as the Chief Financial and Compliance Officer of Group Health Plan, Inc. ("GHP").

3. In Missouri, GHP, through its vendor ACS Recovery Services, subrogates for at least one self-insured plan covered under the Employee Retirement Income Security Act of 1974 (ERISA).

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 16th day of August, 2011.

s/

STATE OF MISSOURI)
) SS.
COUNTY OF ST. LOUIS)

On this 16th day of August, 2011, before me personally appeared David Dickson, to me known to be the person described in and who executed the foregoing instrument, and acknowledged that he executed the same as his free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the City and State aforesaid, the day and year first above written.

s/
Notary Public

My Commission Expires:

September 24, 2013

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

COMMUNITY-RATED HEALTH MAINTENANCE ORGANIZATION CARRIERS

2006

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1930 AMENDMENT NO: 2006
EFFECTIVE: January 1, 2006 EFFECTIVE: January 1, 2006

BETWEEN: The United States Office of Personnel Management *hereinafter called OPM, the Agency, or the Government*

Address: 1900 E Street, NW
Washington, DC 20415-3640

AND

CONTRACTOR: GROUP HEALTH PLAN, INC.
hereinafter also called the Carrier

Address: 111 CORPORATE OFFICE DRIVE, SUITE 400
EARTH CITY, MO 63045

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
FRANK D'ANTONIO	WILLIAM T. STUART
Name of person authorized to execute contract *type or print*)	Name of Contracting Officer *type or print*)
VICE PRESIDENT, SALES & MARKETING Title	CONTRACTING OFFICER Title
s/ Signature	s/ Signature
11/2/05 Date signed	November 18, 2005 Date signed

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PART I - GENERAL PROVISIONS

SECTION 1.1
DEFINITIONS OF FEHB TERMS (JAN 1997)

For purpose of this contract, the following definitions apply:

FEHBP: Federal Employees Health Benefits Program.

Enrollee: The Federal employee, annuitant, former spouse, temporarily-covered former Federal employee or dependent, enrolled under this contract.

Member: The Enrollee and/or an eligible dependent for benefit purposes, and sometimes referred to as subscriber.

Act: The Federal Employees Health Benefits Act, as amended; chapter 89 of title 5, United States Code.

Regulations: 1) The Federal Employees Health Benefits Regulations; part 890, title 5, Code of Federal Regulations, and (2) chapters 1 and 16 of title 48, Code of Federal Regulations.

Benefits: Covered services or payment for covered services set forth in Appendix A, to which Members are entitled to the extent provided by this contract.

Carrier: As defined by chapter 89 of title 5, United States Code, and may be used interchangeably with the term Contractor.

Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

SECTION 1.2
ENTIRE CONTRACT (JAN 2003)

(a) This document as described in the *Table of Contents* constitutes the entire contract between the parties. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this contract. All modifications to the contract must be made in writing to the duly authorized Contracting Officer.

(b) All statements concerning coverage or benefits made by OPM, the Carrier or by any individual covered under this contract shall be deemed representations and not warranties. No such statement shall convey or void any coverage, increase or reduce any benefits under this contract or be used in the prosecution of or defense of a claim under this contract unless it is contained in writing and a copy of the instrument containing the statement is or has been furnished to the Member or to the person making the claim.

SECTION 1.3
ORDER OF PRECEDENCE (JAN 1996)

Any inconsistency in this contract shall be resolved by giving precedence in the following descending order: The Act, the regulations in part 890, title 5, Code of Federal Regulations, the regulations in

chapters 1 and 16, title 48, Code of Federal Regulations, and this contract.

SECTION 1.4
INCORPORATION OF LAWS AND REGULATIONS
(JAN 2002)

(a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890, title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the Contracting Officer will make an equitable adjustment in accordance with the changes clause, Section 5.38 – Changes—Negotiated Benefits Contracts.

SECTION 1.5
RECORDS AND INFORMATION TO BE
FURNISHED BY OPM (SEP 2000)

(a) OPM shall maintain or cause to be maintained records from which the Carrier may determine the names and social security numbers of all Enrollees. OPM, other agencies of the Federal Government, or the FEHB Clearinghouse shall furnish the information to the Carrier at such times and in such form and detail as will enable the Carrier to maintain a currently accurate record of all Enrollees.

(b) The OPM shall direct the agencies to provide the Carrier or the FEHB Clearinghouse, not less often than quarterly, the names of Enrollees enrolled under the contract by payroll office and the premium

paid for those Enrollees for the current pay cycle. The Carrier shall at least quarterly reconcile its enrollment records with those provided by the Government or the FEHB Clearinghouse.

(c) Clerical error (whether by OPM, any other Government agency, the FEHB Clearinghouse, or the Carrier) in keeping records pertaining to coverage under this contract, delays in making entries thereon, or failure to make or account for any deduction of enrollment charges, shall not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. If any person finds relevant facts pertaining to a person covered under this contract to be misstated, and if the misstatement affects the existence, amount, or extent of coverage, the actual facts shall determine whether coverage is in force under the terms of this contract.

SECTION 1.6
CONFIDENTIALITY OF RECORDS (JAN 1991)
(FEHBAR 1652.224-70)

(a) The Carrier shall use the personal data on employees and annuitants that is provided by agencies and OPM, including social security numbers, for only those routine uses stipulated for the data and published annually in the Federal Register as part of OPM's notice of systems of records.

(b) The Carrier shall also hold all medical records, and information relating thereto, of Federal subscribers confidential except as follows:

(1) As may be reasonably necessary for the administration of this contract;

(2) As authorized by the patient or his or her guardian;

(3) As disclosure is necessary to permit Government officials having authority to investigate and prosecute alleged civil or criminal actions;

(4) As necessary to audit the contract;

(5) As necessary to carry out the coordination of benefit provisions of this contract; and

(6) For bona fide medical research or educational purposes. Release of information for medical research or educational purposes shall be limited to aggregated information of a statistical nature that does not identify any individual by name, social security number, or any other identifier unique to an individual.

(c) If the Carrier uses medical records for the administration of the contract, or for bona fide research or educational purposes, it shall so state in the Plan's brochure.

SECTION 1.7
STATISTICS AND SPECIAL STUDIES (JAN 2003)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Chapter 89 of title 5, United States Code.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies as instructed by OPM.

(d) The Carrier shall notify the OPM Contract Representative immediately upon a change in the name or address of the Carrier's contract administrator(s).

SECTION 1.8
NOTICE (JAN 2003)

Where the contract requires that notice be given to the other party, such notice must be given in writing to the address shown on this contract's signature page. To notify OPM, the Carrier must write to the Contracting Officer, unless otherwise specified.

SECTION 1.9
PLAN PERFORMANCE—COMMUNITY-RATED HMO CONTRACTS (JAN 2005)

(a) Detection of Fraud and Abuse. The Carrier shall conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate fraud and abuse internally by Carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members. The program must specify provisions in place for cost avoidance not just fraud detection, along with criteria for follow-up actions. The Carrier must submit to OPM an annual analysis of the costs and benefits of its fraud and abuse program. The Carrier must also submit annual reports to OPM by March 31 addressing the following: the number of cases; dollars identified as lost and recovered; actual and projected savings; cases referred by law enforcement and resolved through negotiated settlement; and number of arrests and

criminal convictions. The report will also include the industry standards checklist.

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Health Plan Employer Data and Information Set (HEDIS), or similar measures developed by accrediting organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or URAC. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier's responsibility.

(c) Patient Safety. The Carrier shall implement a patient safety improvement program. At a minimum, the Carrier shall --

(1) Report to OPM on its current patient safety initiatives;

(2) Report to OPM on how it will strengthen its patient safety program for the future;

(3) Assist OPM in providing its members with consumer information and education regarding patient safety; and

(4) Work with its providers, independent accrediting organizations, and others to implement patient safety improvement programs.

(d) Accreditation. To demonstrate its commitment to providing quality, cost-effective health care, if it has 500 or more Federal enrollees, the Carrier shall continue to pursue and maintain accreditation

according to the steps and timeframes outlined in the carrier's current business plan. The carrier shall submit accreditation changes and business plan updates to its OPM contract representative.

(e) Consumer Assessments of Health Plans Surveys (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the HEDIS Consumer Assessments of Health Plans Surveys (CAHPS) to provide feedback to enrollees on enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.7.

(f) Physician Credentialing. The Carrier is encouraged to use an independent accrediting organization to validate its physician credentialing. If the Carrier's physicians meet the credentialing requirements of the credentialing organization, it has met and exceeds the minimum requirements listed below. Otherwise, the Carrier must demonstrate that it requires the following credential checks of all of its physicians, both during the initial hiring process and during periodic re-credentialing. As an alternative, the Carrier may demonstrate that the following credential checks are performed by a secondary source, such as a hospital.

- Verification of medical school graduation records.
- Routine check with local and/or state medical societies and/or boards.

- Routine check of the Department of Health and Human Services (DHHS) list of debarred providers.
- Routine check of the National Practitioner Data Bank.

(g) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum, the Carrier shall meet the following standards and submit an annual report to OPM on these standards by July 1 of the following contract period.

(1) *Claims Processing Accuracy* - the number of FEHB claims processed accurately divided by the total number of FEHB claims processed for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 95 percent of FMB claims must be processed accurately.

(2) *Coordination of Benefits (COB)* - the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims for COB.

(3) *Claims Timeliness* - the average number of working days from the date the Carrier receives an FEHB claim to the date it adjudicates it (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.

REQUIRED STANDARD: The Carrier adjudicates 95 percent of claims within 30 working days.

(4) *Processing ID cards on change of plan or option* - the number of calendar days from the date the Carrier receives the enrollment from the enrollee's agency or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier issues the ID card within fifteen calendar days after receiving the enrollment from the enrollee's agency or retirement system except that the Carrier will issue ID cards resulting from an open season election within fifteen calendar days or by December 15, whichever is later.

(5) *Member Inquiries* - the number of working days taken to respond to an FEHB member's written inquiry, expressed as a cumulative percentage, for the given time period.

REQUIRED STANDARD: The Carrier responds to 90 percent of inquiries within 15 working days (including internet inquiries).

(6) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. *Except that*, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) *Call Answer Timeliness* - the average number of seconds elapsing before the Carrier connects a member's telephone call to its service representative.

REQUIRED STANDARD: On average, no more than 30 seconds elapse before the Carrier connects a member's telephone call to its service representative.

(ii) *Telephone Blockage Rate* - the percentage of time that callers receive a busy signal when calling the Carrier.

REQUIRED STANDARD: No more than 5% of callers receive a busy signal.

(iii) *Telephone Abandonment Rate* - the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.

REQUIRED STANDARD: On average, enrollees abandon the effort no more than 5 percent of the time.

(iv) *Initial Call Resolution* - the percentage of issues resolved during the initial call.

REQUIRED STANDARD: On average, caller's issues must be resolved during the initial call at least 60% of the time.

(7) *Responsiveness to FEHB Member Requests for Reconsideration*:

REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given time period, within 30 days after receipt by the Carrier, the Carrier shall affirm the denial in writing to the FEHB member, pay the claim, provide the service, or request additional information reasonably necessary to make a determination.

(h) Quality Assurance Plan. The Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance/fraud and abuse prevention standards.

(i) Reporting Compliance. The Carrier shall keep complete records of its quality assurance procedures and fraud prevention program and the results of their implementation and make them available to the Government as determined by OPM.

(j) Correction of deficiencies. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph (j) after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

(k) In order to allow sufficient implementation time, the Contracting Officer with notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (i).

SECTION 1.10
NOTICE OF SIGNIFICANT EVENTS[1] (JUL 2005)
(FEHBAR 1652.222.70)

(a) The Carrier agrees to notify the Contracting Officer of any Significant Event within ten (10) work-

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[1] In Section 1.10, 13d is not applicable to community-rated HMO contracts.

ing days after the Carrier becomes aware of it. As used in this section, a Significant Event is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the Carrier's ability to meet its obligations under this contract, including, but not limited to, any of the following:

(1) Disposal of major assets;

(2) Loss of 15% or more of the Carrier's overall membership;

(3) Termination or modification of any contract or subcontract if such termination or modification might have a material effect on the Carrier's obligations under this contract;

(4) Addition or termination of provider agreements;

(5) Any changes in underwriters, reinsurers or participating plans;

(6) The imposition of or notice of the intent to impose, a receivership, conservatorship, or special regulatory monitoring;

(7) The withdrawal of, or notice of intent to withdraw State licensing, HHS qualification, or any other status under Federal or State law;

(8) Default on a loan or other financial obligation;

(9) Any actual or potential labor dispute that delays or threatens to delay timely performance or substantially impairs the functioning of the Carrier's facilities or facilities used by the Carrier in the performance of the contract;

(10)Any change in its charter, constitution, or by-laws which affects any provision of this contract or the Carrier's participation in the Federal Employees Health Benefits Program;

(11)Any significant changes in policies and procedures or interpretations of the contract or brochure which would affect the benefits available under the contract or the costs charged to the contract;

(12)Any fraud, embezzlement or misappropriation of FEHB funds; or

(13)Any written exceptions, reservations or qualifications expressed by the independent accounting firm (which ascribes to the standards of the American Institute of Certified Public Accountants) contracted with by the Carrier to provide an opinion on its annual financial statements.

(b) Upon learning of a Significant Event OPM may institute action, in proportion to the seriousness of the event, to protect the interest of Members, including, but not limited to--

(1) Directing the Carrier to take corrective action;

(2) Suspending new enrollments under this contract;

(3) Advising Enrollees of the Significant Event and providing them an opportunity to transfer to another plan;

(4) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account;

(5) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the Significant Event; or

(6) Terminating this contract pursuant to Section 1.15, *Renewal and Withdrawal of Approval.*

(c) Prior to taking action as described in paragraph (b) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(d) The Carrier will insert this clause in any subcontract or subcontract modification if the amount of the subcontract or modification charged to the FEHB Program (or in the case of a community-rated carrier, applicable to the FEHB Program) equals or exceeds $550,000 and is at least 25 percent of the total subcontract cost. The amount of the dollar charge to the FEHB Program shall be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act pursuant to 41 U.S.C. 254b(a)(7).

SECTION 1.11
FEHB 1NSPECTION[2] (JUL 2005) (FEHBAR 1652.246-70)

(a) The Contracting Officer, or an authorized representative of the Contracting Officer, has the right to inspect or evaluate the work performed or being performed under the contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unreasonably delay the work.

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[2] The references to Large Providers are not applicable to community-rated HMO contracts.

(b) The Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all books and records relating to the contract for purposes of the Contracting Officer's determination of the Carrier's subcontractor or Large Provider's compliance with the terms of the contract, including its payment (including rebate and other financial arrangements) and performance provisions. The Contractor shall make available at its office at all reasonable times those books and records for examination and audit for the record retention period specified in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), 48 CFR 1652.204-70. This subsection is applicable to subcontract and Large Provider Agreements with the exception of those that are subject to the "Audits and Records — Negotiation" clause, 48 CFR 52.215-2.

(c) If the Contracting Officer, or an authorized representative of the Contracting Officer, performs inspection, audit or evaluation on the premises of the Carrier, the subcontractor, or the Large Provider, the Carrier shall furnish or require the subcontractor or Large Provider to furnish all reasonable facilities for the safe and convenient performance of these duties.

(d) The Carrier shall insert this clause, including this subsection (d), in all subcontracts for underwriting and claim payments and administrative services and in all Large Provider Agreements and shall substitute "contractor", "Large Provider," or other appropriate reference for the term "Carrier."

SECTION 1.12
CORRECTION OF DEFICIENCIES (JAN 1997)

(a) The Carrier shall maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meet its obligations under this contract. If the OPM determines that the Carrier does not demonstrate the ability to meet its obligations under this contract, the OPM shall notify the Carrier of the asserted deficiencies. The Carrier agrees that, within ten (10) working days following notification, it shall present detailed plans for correcting the deficiencies. These plans shall be presented in a form prescribed by the OPM. Pending submission or implementation of plans required under this Section, the OPM may institute action as it deems necessary to protect the interests of Members, including, but not limited to:

(1) Suspending new enrollments under this contract;

(2) Advising Enrollees of the asserted deficiencies and providing them an opportunity to transfer to another plan;

(3) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account; or

(4) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would he adversely affected by the deficiency.

(b) The Carrier agrees that failure to submit or to diligently implement plans which are required under this Section shall constitute sufficient grounds for termination of this contract pursuant to Section 1.15, *Renewal and Withdrawal of Approval*.

(c) Prior to taking action as described in paragraph (a) the OPM shall notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall include the substance of this clause in the contract with its underwriter and substitute an appropriate term for "Carrier."

SECTION 1.13
INFORMATION AND MARKETING MATERIALS
(JAN 2005)

(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The Carrier bears full responsibility for the accuracy of its FEHB brochure, OPM, in its solo discretion, may order the Carrier to produce and distribute the agreed upon brochure text, in a format and quantity approved by OEM, including an electronic 508 compliant brochure version, Section 508 of the Rehabilitation Act of 1973, as amended 29 U.S.C. § 794d, for OPM's web site. This formatted document is referred to as the FEHB brochure. The Carrier shall distribute the FEHB brochure on a timely basis to all Federal employees, annuitants, former spouses and former employees and dependents enrolled in the Plan. The Carrier shall also distribute the document(s) to Federal agencies to be made available to such individuals who are eligible to enroll under this contract. At the direction of OPM, the Carrier shall produce and distribute an audio cassette version of the approved language. The Carrier may print additional FEHB brochures for distribution for its own use, but only in the approved format and at its own expense.

(b) Supplemental material. Only marketing materials or other supplemental literature prepared in

accordance with FEHBAR 1652.203-70 (Section 1.14 of this contract) may be distributed or displayed at or through Federal facilities.

(c) The Carrier shall reflect the statement of benefits in the agreed upon brochure text included at Appendix A of this contract, verbatim, in the FEHB brochure.

(d) OPM may order the Carrier to prepare an addendum or reissue the FEHB brochure or any piece(s) of supplemental marketing material at no expense to the Government if it is found to not conform to the agreed upon brochure text and/or supplemental marketing materials preparations described in paragraphs (a), (b) and (c) of this section.

SECTION 1.14
MISLEADING, DECEPTIVE OR UNFAIR ADVERTISING (JAN 1991) (FEHBAR 1652.203-70)

(a) The Carrier agrees that any advertising material including that labeled promotional material, marketing material, or supplemental literature, shall be truthful and not misleading.

(b) Criteria to assess compliance with paragraph (a) of this clause are available in the FEHB Supplemental Literature Guidelines which are developed by OPM and should be used, along with the additional guidelines set forth in FEHBAR 1603.702, as the primary guide in preparing material; further guidance is provided in the NAIC *Advertisements of Accident and Sickness Insurance Model Regulation*. The guidelines contained in this document are periodically updated and provided to the Carrier by OPM.

(c) Failure to conform to paragraph (a) of this clause may result in a reduction in the service charge, if appropriate, and corrective action to pro-

tect the interest of Federal Members. Corrective action will be appropriate to the circumstances and may include, but is not limited to the following actions by OPM:

(1) Directing the Carrier to cease and desist distribution, publication, or broadcast of the material;

(2) Directing the Carrier to issue corrections at the Carrier's expense arid in the same manner and media as the original material was made; and

(3) Directing the Carrier to provide, at the Carrier's expense, the correction in writing by certified mail to all enrollees of the Plan(s) that had been the subject of the original material;

(d) Egregious or repeated offenses may result in the following action by OPM:

(1) Suspending new enrollments in the Carrier's Plan(s);

(2) Providing Enrollees an opportunity to transfer to another plan; and

(3) Terminating the contract in accordance with Section 1.15, *Renewal and Withdrawal of Approval.*

(e) Prior to taking action as described in paragraphs (c) and (d) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(f) The Carrier shall incorporate this clause in subcontracts with its underwriter, if any, and other subcontractors directly involved in the preparation or distribution of such advertising material and shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL
(JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of non-renewal is given either by OPM or the Carrier not less than 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. 8902(e). After OPM notifies the Carrier of its intent to terminate the contract, OPM may take action as it deems necessary to protect the interests of Members, including but not limited to-

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies; and

(3) Providing Enrollees an opportunity to transfer to another plan.

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds that the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

SECTION 1.16
[RESERVED]

SECTION 1.17
NOVATION AGREEMENT (JAN 1996)

The agreement at FEHBAR 1642.1204 shall be submitted for approval to OPM when the Carrier's assets or the entire portion of the assets pertinent' to

the performance of this contract, as determined by the Government, are transferred.

SECTION 1.18
AGREEMENT TO RECOGNIZE CARRIER'S CHANGE OF NAME (JAN 1996)

The agreement at FEHBAR 1642.1205 shall be submitted for approval to OPM when the Carrier changes its name and the Government's and Contractor's rights and obligations remain unaffected.

SECTION 1.19
CERTIFICATION UNDER P. L. 104-191 (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) (JAN 1998)

The Carrier will issue a certification of coverage for members in accordance with the regulations issued by the Department of Health and Human Services.

SECTION 1.20
PATIENTS' BILL OF RIGHTS (JAN 1999)

(a) The Carrier shall implement the recommendations in the Health Care Consumer Bill of Rights and Responsibilities ("Patients' Bill of Rights") in accordance with OPM guidance.

(b) During the Carrier's provider contract renewal process, the Carrier shall make any necessary modifications to such provider contracts to comply with the recommendations of the Patients' Bill of Rights in accordance with OPM guidance. All new provider contracts with the Carrier shall comply with the recommendations of the Patients' Bill of Rights in accordance with OPM guidance.

SECTION 1.21
ADMINISTRATIVE SIMPLIFICATION-HIPAA
(JAN 2003)

(a) The Carrier shall implement and be in compliance with the Department of Health and Human Services (DHHS) regulations regarding the standards for electronic transactions and code sets on the date DHHS specifies. The regulations at 45 CFR parts 160 and 162 are incorporated by reference in this contract.

(b) The Carrier shall implement and be in compliance with the DHHS regulations regarding the standards for privacy of individually identifiable health information on the date DHHS specifies. The regulations at 45 CFR parts 160 and 164 are incorporated by reference in this contract.

SECTION 1.22
HIPAA COMPLIANCE (JAN 1998)

(a) The Carrier shall comply with and shall take all steps reasonably necessary to ensure that its affiliates, subcontractors, and agents comply with the guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations. "Guaranteed availability" means the Carrier, affiliates, subcontractors, and agents do not engage in practices that: 1) decline to offer health insurance coverage (as defined in section 2791(b)(1) of the Public Health Service Act "the Act") to, or deny enrollment of an eligible individual (as defined in section 2741(b) of the Act); or, 2) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(a) of the Act), with respect to such coverage.

(b) A State or Federal enforcement action as the result of noncompliance with the requirements of HIPAA is a significant event under Section 1.10 of this contrail, Notice of Significant Events. If the Carrier, or any affiliate, subcontractor, or agent, is notified of any enforcement action by any Federal or State authority with regard to HIPAA compliance, the Carrier must notify OPM within ten working days of learning of the action.

SECTION 1.23
NOTICE ON TERMINATION OF FEHBP OR PROVIDER CONTRACT (HMO) (JAN 2003)

(a) Members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy at the time a carrier terminates (1) all or part of its FEBHP contract or (2) the members' specialty provider contract for reasons other than cause, may be able to continue to see their specialty provider for up to 90 days or through their postpartum care.

(b) The Carrier shall notify its members in writing of its intent to terminate all or part of its FEHBP contract, including service area reductions, or the members specialty provider contract, for reasons other than cause, in order to allow sufficient time for the members to arrange for continued care after the 90-day period or their postpartum care, whichever applies. The Carrier shall send the required notice to the member if the Carrier has in its records an address for the member different from the enrollee's address; otherwise, the Carrier may send the notice to the enrollee. The Carrier shall send the notice in time to ensure it is received by the members no less than 90 days prior to the date it terminates the contract, unless the Carrier demonstrates it was pre-

vented from doing so for reasons beyond its control. The Carrier's prompt notice will ensure that the notification period and the transitional care period run concurrently.

SECTION 1.24
TRANSITIONAL CARE (JAN 2003)

(a) "Transitional care" is specialized care provided for up to 90 days or through the postpartum period, whichever is later, to a member who is undergoing treatment for a chronic or disabling condition or who is in the second or third trimester of pregnancy when the Carrier terminates (1) all or part of its FEHBP contract or (2) the member's specialty provider contract for reasons other than cause. The 90-day period begins the earlier of the date the member receives the notice required under Section 1.23, Notice on Termination of FEHBP or Provider Contract (HMO), or the date the Carrier's or the provider's contract ends.

(b) The Carrier shall ensure the following:

(1) If it terminates a part of its FEHB contract or a specialty provider contract other than for cause, it allows members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period, whichever is later, under the same terms and conditions that existed at the beginning of the transitional care period; and (2) If it enrolls a new member who voluntarily changed carriers because the member's former carrier was no longer available in the FEHB Program, it provides transitional care for the member if he or she is undergoing treatment for a chronic or

disabling condition or is in the second or third trimester of pregnancy for up to 90 days, or through the postpartum period, whichever is later, under the same terms and conditions the member had under the prior carrier.

(c) In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to members;

(2) require the specialty provider to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient; and,

(3) require the specialty to give all necessary information to the Carrier for quality assurance purposes.

SECTION 1.25
DISCLOSURE NOTICE UNDER P.L. 108-173
(MEDICARE MODERNIZATION ACT OF 2003)
(JAN 2006)

The Carrier will issue, as part of its FEHB benefit's brochure, a disclosure notice concerning creditable prescription drug coverage in accordance with the regulation at 42 CFR §423.56 issued by the Department of Health and Human Services.

PART II - BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1999)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a

prerequisite to such enrollment, complete a Health Benefits Election Form or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) The Carrier shall, subject to the approval of the Contracting Officer, define an area from which it will accept enrollments. The Carrier may limit enrollment to individuals residing or employed inside the approved area.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any claim forms as necessary.

SECTION 2.2
BENEFITS PROVIDED (JAN 1999)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited

by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier, after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each ease when the Carrier provides a benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shalt document in writing prior to the provision of such benefit the reasons and justification for its determination. Such payment or provision of services or supplies shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2003)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request; *provided*, however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.11 *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) When members ore required to file claims for covered benefits, benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for receiving benefits and filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where

timely filing was prevented by administrative operations of Government or, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition. The examinations shall be made at the expense of the Carrier.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) When claim filing is required, benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and, when claim filing is required, may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and when claim filing is required, the Carrier may reimburse that person for any covered medical service or supply.

(4) Compliance with the HIPAA Privacy Rule. The Carrier may pay benefits to a covered person other than the Enrollee when in the exercise of its discretion the Carrier decides that such action is

necessary to comply with the HIPAA Privacy Rule, 45 C.F.R. §164.500 et seq.

(5) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(4) shall fully discharge the Carrier to the extent of such payment.

(g) *Erroneous Payments*. If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall--

(1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases to a collection attorney or a collection agency if the debt is not recovered.

(5) Make a prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved.

(7) Maintain records that document individual unrecovered erroneous pay nent collection activities for audit or future reference.

SECTION 2.4
TERMINATION OF COVERAGE AND
CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts, The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5
SUBROGATION (JAN 1998)

(a) The Carrier shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members, according to the following rules:

(1) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is permitted, and in which the Carrier subrogates for non-FEHB members;

(2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carder subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA);

(3) The Carrier shall not subrogate if it is doing business in a State that prohibits subrogation, and in which the Carrier does not subrogate for any plan covered under ERISA;

(4) For Carriers doing business in more than one State, the Carrier shall apply the rules in (1) through (3) of this subsection according to the rule applicable to the State in which the subrogation would take place.

(b) The Carrier's subrogation procedures and policies shall be shown in the agreed upon brochure text or made available to the enrollees upon request.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 2001)
(FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC *Group Coordination of Benefits*

Model Regulation, Rules for Coordination of Benefits, as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC *Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits*, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term. *[NOTE: Subsection 2.6(b) will not be applied to this community-rated carrier. When there is double coverage for covered benefits, other than emergency services from non-Plan providers, the Health Maintenance Organization Carrier will continue to provide benefits in full, but will seek payment for the services and supplies provided, to the extent that the services and supplies are covered by the other coverage, no-fault automobile insurance or other primary plan. Likewise, Subsection 2.6(d) is not applicable to community-rated carriers.]*

SECTION 2.7
DEPARMENT AND OTHER SANCTIONS (JAN 1999)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 CFR 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the earlier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CPR 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995) (FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on

the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if

the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is noti-

fied that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may

make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9
PROTECTION OF MEMBERS AGAINST
PROVIDER CLAIMS (JAN 1996)

(a) The Carrier shall provide the Contracting Officer with evidence that its contracts with providers (hospitals and physicians) contain a provision that, in the event of Carrier insolvency, or inability to pay expenses for any reason, the providers shall not look to Members for payment. The Carrier agrees that over 90 percent of the total benefit cost under this contract will be provided under such contracts with providers; or

(b) In lieu of subsection (a) above, the Contracting Officer may accept such other combinations of coverage which provide protection of Members against provider claims as defined in the NAIC (National Association of Insurance Commissioners) Model HMO Act, as amended; or

(c) The Carrier shall provide the Contracting Officer with documentation that it has such other appropriate combinations of coverage which would provide protection of Members against provider claims in the event of Currier insolvency, or inability to pay expenses for any reason.

(d) The Carrier shall notify the Contracting Officer as soon as it is aware that it will not be able to satisfy the requirements stated in subsections (a), (b), or (c) above.

SECTION 2.10
INDEPENDENT LABORATORIES (JAN 1991)

In order to assure a minimum standard of quality for laboratory services, the Carrier agrees that it will not use independent laboratories which do not comply with Medicare or similar standards.

SECTION 2.11
CLAIMS PROCESSING (JAN 2001)

A standardized claims filing process shall be used by all FEBH carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) The majority of provider claims should be submitted electronically;

(2) All providers shall be notified that future claims must be submitted electronically, or on the Centers for Medicare and Medicaid Services 1500 form or the UB-92 form;

(3) The Carrier shall not use any unique provider claim form(s) for FEHB member claims;

(4) The Carrier should reject all claims submitted on forms other than the CMS 1500 form or the UB-92 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.12
CALCULATION OF COST SEARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons.

SECTION 2.13
BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 2006)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A and Appendix D of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, copayments, and the balance between the Medicare approved amount and the Medicare limiting charge made by nonparticipating providers.

SECTION 2.14
CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER (JAN 2004)

(a) The Carrier shalt fulfill all of the requirements agreed to under the contract that continue after termination. The order of precedence for the applicable laws, regulations, and the contract are listed in Section 1.3.

(b) Contract requirements extend beyond the date of the Carrier's termination until the effective date of the new enrollment including processing and paying claims incurred prior to the effective date of the new enrollment.

(c) When the prior carrier is discontinued in whole or in part, the gaining carrier assumes full coverage on the effective date of the new enrollment.

SECTION 2.15
COORDINATION OF PRESCRIPTION DRUG BENEFITS WITH MEDICARE (JAN 2006)

(a) The Carrier shall comply with the Center for Medicare and Medicaid Services' (CMS) Part D Coordination of Benefits Guidance when the mechanisms and systems indicated in this guidance are in place and functioning properly. This guidance provides the requirements and procedures for coordination of benefits between Part D plans and other providers of prescription drug coverage.

(b) For Medicare Part B covered prescription drugs, the Carrier will coordinate benefits with Medicare except when such prescription drugs are purchased from retail or mail order pharmacies. The Carrier may pay its benefits on retail pharmacy or mail order drugs eligible for Medicare Part B coverage.

PART III - PAYMENTS, CHARGES AND ACCOUNTING

SECTION 3.1
PAYMENTS (JAN 2003) (FEHBAR 1652.232-70)

(a) OPM will pay to the Carrier, in full settlement of its obligations under this contract, subject to adjustment for error or fraud, the subscription charges received for the Plan by the Employees Health Benefits Fund (hereinafter called the Fund) less the amounts set aside by OPM for the Contingency Reserve and for the administrative expenses of OPM, amounts assessed under FEHBAR 1609.7101-2, and amounts for obligations due pursuant to paragraph (b) of this clause, plus any payments made by OPM from the Contingency Reserve.

(b) OPM will notify the Carrier of amounts due for outstanding obligations under the contract. Not later than 60 days after the date of written notice from OPM, the Carrier shall reimburse OPM. If payment is not received within the prescribed time frame, OPM shall withhold the amount due from the subscription charges owed the Carrier under paragraph (a) of this clause.

(c) The specific subscription rates, charges, allowances and limitations applicable to the contract are set forth in Appendix B.

(d) Recurring payments from premiums shall be due and payable not later than thirty days after receipt by the Fund. The Contracting Officer may authorize special nonrecurring payments from the Contingency Reserve in accordance with OPM's regulations.

(e) In the event this contract between the Carrier and OPM is terminated or not renewed in accordance with General Provision 1.15, *Renewal and Withdrawal Approval*, the Contingency Reserve of the Carrier held by OPM shall be available to the Carrier to pay the necessary and proper charges against this contract to the extent that the reserves held by the Carrier are insufficient for that purpose.

[NOTE: The adjustment for error or fraud referenced in paragraph (a) and the necessary and proper charges against this contract if the contract is terminated or not renewed, referenced in subsection (d), shall be limited to the subscription rate and any contingency reserve payment otherwise provided for in this contract and shall not include claim charges or other expenses attributable to individual Members. Further, FEHBAR 1652.216-70, Accounting and Price Adjustment, applies if any adjustment to the contract price is determined.]

SECTION 3.2
ACCOUNTING AND PRICE ADJUSTMENT (JAN 2003) (FEHBAR 1652.216-70)

(a) *Annual Accounting Statement.* The Carrier, not later than 90 days after the end of each contract period, shall furnish to OPM for that contract period an accounting of its operations under the contract. The accounting shall be in the form prescribed by OPM.

(b) *Adjustment.* (1) This contract is community rated as defined in FEHBAR 1602.170-2.

(2) The subscription rates agreed to in this contract shall be equivalent to the subscription rates given to the Carrier's similarly sized subscriber groups (SSSGs) as defined in FEHBAR 1602.170-13.

(3) If, at the time of the rate reconciliation, the subscription rates are found to be lower than the equivalent rates for the lower of the two SSSGs, the Carrier may include an adjustment to the Federal group's rates for the next contract period.

(4) If, at the time of the rate reconciliation, the subscription rates are found to be higher than the equivalent rates for the lower of the two SSSGs, the Carrier shall reimburse the Fund, for example, by reducing the FEHB rates for the next contract term to reflect the difference between the estimated rates and the rates which are derived using the methodology of the lower rated SSSG.

(5) No upward adjustment in the rate established for this contract will be allowed or considered by the Government or will be made by the Carrier in this or in any other contract period on the basis of actual costs incurred, actual benefits provided, or actual size or composition of the FEHBP group during this contract period.

(6) In the event this contract is not renewed, neither the Government nor the Carrier shall be entitled to any adjustment or claim for the difference between the subscription rates prior to rate reconciliation and the actual subscription rates.

SECTION 3.3
RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA (JAN 2004) (FEHBAR 1652.215-70)

As prescribed in 1615.407-1, the following clause shall be inserted in FEHBP contracts exceeding the threshold at FAR 15.403-4(a)(1) that are based on a combination of cost and price analysis (community rated):

(a) If any rate established in connection with this contract was increased because (1) the Carrier-submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not complete, accurate, or current as certified in the Certificate of Accurate Cost or Pricing Data (FEHBAR 1615.406-2); (2) the Carrier submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not accurate as represented in the rate proposal documents; (3) the Carrier developed FEHBP rates with a rating methodology and structure inconsistent with that used to develop rates for similarly sized subscriber groups (see FEHBAR §1602.170-13) as certified in the Certificate of Accurate Cost or Pricing Data for Community Rated Carriers; or (4) the Carrier submitted or kept in its files in support of the FEHBP rate, data or information of any description that were not complete, accurate, and current—then, the rate shall be reduced in the amount by which the price was increased because of the defective data or information.

(b)(1) If the Contracting Officer determines under paragraph (a) of this clause that a price or cost reduction should be made, the Carrier agrees not to raise the following matters as a defense:

(i) The Carrier was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the contract would not have been modified even if accurate, complete, and current cost or pricing data had been submitted or maintained and identified.

(ii) The Contracting Officer should have known that the cost or pricing data in issue were defective even though the Carrier took no affirmative action to

bring the character of the data to the attention of the Contracting Officer.

(iii) The contract was based on an agreement about the total cost of the contract and there was no agreement about the cost of each item procured under the contract.

(iv) The Carrier did not submit or keep in its files a Certificate of Current Cost or Pricing Data.

(2)(i) Except as prohibited by subdivision (b)(2)(ii) of this clause, an offset in an amount determined appropriate by the Contracting Officer based upon the facts shall be allowed against the amount of a contract price reduction if--

(A) The Carrier certifies to the Contracting Officer that, to the best of the Carrier's knowledge and belief, the Carrier is entitled to the offset in the amount requested; and

(B) The Carrier proves that the cost or pricing data were available before the date of agreement on the price of the contract (or price of the modification) and that the data were not submitted before such date.

(ii) An offset shall not be allowed if—

(A) The understated data was known by the Carrier to be understated when the Certificate of Current Cost or Pricing Data was signed; or

(B) The Government proves that the facts demonstrate that the contract price would not have increased in the amount to be offset even if the available data had been submitted before the date of agreement on price.

(c) When the Contracting Officer determines that the rates shall be reduced and the Government

is thereby entitled to a refund, the Carrier shall be liable to and shall pay the FEHB Fund at the time the overpayment is repaid-

(1) Simple interest on the amount of the overpayment from the date the overpayment was paid from the FEHB Fund to the Carrier until the date the overcharge is liquidated. In calculating the amount of interest due, the Carrier shall use the quarterly rate determinations by the Secretary of the Treasury under the authority of 26 U.S.C. 6621(a)(2) applicable to the periods the overcharge was retained by the Carrier shall be used; and,

(2) A penalty equal to the amount of overpayment, if the Carrier knowingly submitted cost or pricing data which was incomplete, inaccurate, or noncurrent.

SECTION 3.4
CONTRACTOR RECORDS RETENTION (JUL 2005) (FEHBAR 1652.204-70)

Notwithstanding the provisions of Section 5.7 (FAR 52.215-2(f)) *Audit and Records Negotiation* the Carrier will retain and make available all records applicable to a contract term that support the annual statement of operations and, for contracts that equal or exceed the threshold at FAR 15.403-4(a)(1), the rate submission for that contract term for a period of six years after the end of the contract term to which the records relate. This includes all records of Large Provider Agreements and subcontracts that equal or exceed the threshold requirements. In addition, individual enrollee and/or patient claim records will be maintained for six years after the end of the contract term to which the claim records relate. This clause is effective prospectively as of the 2005 contract year.

SECTION 3.5
APPROVAL FOR ASSIGNMENT OF CLAIMS (JAN 1991) (FEHBAR 1652.232-73)

(a) Notwithstanding the provisions of Section 5.35 [FAR 52.232-23], *Assignment of Claims*, the Carrier shall not make any assignment under the Assignment of Claims Act without the prior written approval of the Contracting Officer.

(b) Unless a different period is specified in the Contracting Officer's written approval, an assignment shall be in force only for a period of one year from the date of the Contracting Officer's approval. However, assignments may be renewed upon their expiration.

SECTION 3.6
DISCREPANCIES BETWEEN ENROLLMENT AND PAYMENTS TO CARRIER (JAN 2002)

(a) The OPM and the Carrier recognize that the portion of subscription payments under Section 3.1(a) forwarded by OPM to the Carrier for Enrollees may not be consistent with the Carrier's reconciliation of enrollment under Section 1.5. Therefore, the OPM and the Carrier agree:

(1) That any individual discrepancies discovered in the course of reconciliation, in which the agency certifying officer and the Carrier agree as to the enrollment status of the individual, shall be corrected by the applicable agency to reflect the valid enrollment(s). If the reconciliation indicates that the subscription payments were not made or were made in error, appropriate adjustments shall be made by the agency to the Fund pursuant to law. Any adjustment in the subscription charges received by the

Fund from the agency as a result of a reconciliation shall be forwarded by OEM under Section 3.1(a); and

(2) That the rates in Appendix B include an adjustment to the subscription charges equal to one percent in full resolution of all discrepancies not corrected under Section 3.6(b)(1).

(b) In consideration of the adjustments in Section 3.6(a)(1) and (2), the Carrier accepts the adjustment to the subscription charges in full resolution of all obligations of the Government in connection with the subscription payments as described in this section 3.6, and waives any rights it may have to claims for subscription payments under Section 3.1(a).

(c)(1) The FEHB Clearinghouse will facilitate the reconciliation of enrollments between carriers and Federal agencies. The Carrier shall pay a pro rata share based on its proportion of FEHB premiums as determined by OPM for the cost of developing the Clearinghouse.

(2) OEM shall withhold the amount due from the Carrier's subscription charges under the authority of FEHBAR 1652.232-70, Payments—Community-Rated Contracts, and shall forward payment to the FEHB Clearinghouse.

SECTION 3.7
SURVEY CHARGES (JAN 2002)

(a) If the Carrier participates in an FEHB annual consumer assessment survey, it shall pay OPM's contractor a pro rata share of the total cost of consolidating and reporting the survey results to OPM. The Carrier shall pay a separate fee for each plan option and/or rating area. The Carrier agrees to pay the contractor's invoice within 30 days of the billing date. If the Carrier does not remit payment to the

contractor within 60 days of the billing date, OPM shall withhold the amount due from the Carrier's subscription charges according to FEHBAR 1652.232-70, Payments—community-rated contracts, and forward payment to the contractor.

(b) Costs incurred by the Carrier for contracting with a vendor to conduct the survey shall be the Carrier's responsibility.

SECTION 3.8
TAXPAYER IDENTIFICATION NUMBER (JAN 2000) (FEHBAR 1652.204-73)

(a) *Definitions.*

"Common parent," as used in this provision, means that corporate entity that owns or controls an affiliated group of corporations that files its Federal income tax returns on a consolidated basis, and of which the Carrier is a member.

"Taxpayer Identification Number (TIN)," as used in this provision, means the number required by the Internal Revenue Service (IRS) to be used by the Carrier in reporting income tax and other returns.

(b) The Carrier must submit the information required in paragraphs (d) through (f) of this clause to comply with debt collection requirements of 31 U.S.C. 7701(c) and 3325(d), reporting requirements of 26 U.S.C. 6041, 6041A, and 6050M, and implementing regulations issued by the IRS. The Carrier is subject to the payment reporting requirements described in Federal Acquisition Regulation (FAR) 4,904. The Carrier's failure or refusal to furnish the information will result in payment being withheld until the TIN number is provided.

(c) The Government may use the TIN to collect and report on any delinquent amounts arising out of the Carrier's relationship with the Government (31 U.S.C. 7701(c)(3)). The TIN provided hereunder may be matched with IRS records to verify its accuracy.

(d) *Taxpayer Identification Number (TIN).*

TIN: *[redacted]*-2307

(e) Type of organization.

☐ Sole proprietorship;
☐ Partnership;
✓ Corporate entity (not tax-exempt);
☐ Corporate entity (tax-exempt);
☐ Other _____

(f) Common parent.

☐ Carrier is not owned or controlled by a common parent as defined in paragraph (a) of this clause.
☐ Name and TIN of common parent;

Name Coventry Health Care
TIN _____

(End of Clause)

SECTION 3.9
HIGH DEDUCTIBLE HEALTH PLANS (HDHP) WITH SIMILARLY SIZED SUBSCRIBER GROUPS (SSSGS)

If separate SSSGs are needed for a High Deductible Health Plan (FIDHP) because it is rated separately from the Carrier's traditional HMO's or the Carrier has no other plans in that region, the two SSSGs will be chosen based on size. If the Carrier's HDHPs are rated Adjusted Community Rated (ACR) and the groups closest in size are rated differently, that will be acceptable if that is the Carrier's current policy and it is done in a consistent matter. All other

rules for choosing SSSGs, will be consistent with the current rules for choosing SSSGs for traditional plans. If either of the SSSGs is given a discount, that discount should only be passed to the insurance portion and not the pass through.

PART IV -- SPECIAL PROVISIONS

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2003) (FAR 52.252.4)

Portions of this contract are altered as follows:

(--) Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity,

(--) Section 1.14, *Misleading, Deceptive, or Unfair Advertising*, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carriers should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.702.

(--) Section 5.58. The reference to Central Contractor Registration in FAR 52.232-33, Payment by

Electronic Funds Transfer-Central Contractor Registration, is not applicable to this contract.

PART V - REQUIRED CLAUSES

SECTION 5.1
DEFINITIONS (JULY 2004) (FAR 52.202-1)

(a) When a solicitation provision or contract clause uses a word or term that is defined in the Federal Acquisition Regulation (FAR), the word or term has the same meaning as the definition in FAR 2.101 in effect at the time the solicitation was issued, unless--

(1) The solicitation or amended solicitation provides a different definition;

(2) The contracting parties agree to a different definition;

(3) The part, subpart, or section of the FAR where the provision or clause is prescribed provides a different meaning; or

(4) The word or term is defined in FAR Part 31, for use in the cost principles and procedures.

(b) The FAR index is a guide to words and terms the FAR defines and shows where each definition is located. The FAR Index is available via the Internet at http://www.acqnet.gov at the end of the FAR, after the FAR Appendix.

SECTION 5.2
[RESERVED]

SECTION 5.3
GRATUITIES (APR 1984) (FAR 52.203-3)

(a) The right of the Contractor to proceed may be terminated by written notice if, after notice and hearing, the agency head or a designee determines that the Contractor, its agent, or another representative -

(1) Offered or gave a gratuity (e.g., an entertainment or gift) to an officer, official, or employee of the Government; and

(2) Intended, by the gratuity, to obtain a contractor favorable treatment under a contract.

(b) The facts supporting this determination may be reviewed by any court having lawful jurisdiction.

(c) If this contract is terminated under paragraph (a) above, the Government is entitled -- (1) To pursue the same remedies as in a breach of the contract; and (2) In addition to any other damages provided by law, to exemplary damages of not less than 3 nor more than 10 times the cost incurred by the Contractor in giving gratuities to the person concerned, as determined by the agency head or a designee. (This subparagraph (c)(2) is applicable only if this contract uses money appropriated to the Department of Defense.)

(d) The rights and remedies of the Government provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

SECTION 5.4
COVENANT AGAINST CONTINGENT FEES (APR 1984) (FAR 52.203-5)

(a) The Contractor warrants that no person or agency has been employed or retained to solicit or obtain this contract upon an agreement or understanding for a contingent fee, except a bona fide employee or agency. For breach or violation of this warranty, the Government shall have the right to annul this contract without liability or, in its discretion, to deduct from the contract price or consideration, or otherwise recover, the full amount of the contingent fee.

(b) "Bona fide agency," as used in this clause, means an established commercial or selling agency, maintained by a contractor for the purpose of securing business, that neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds itself out as being able to obtain any Government contract or contracts through improper influence. "Bona fide employee," as used in this clause, means a person, employed by a contractor and subject to the contractor's supervision and control as to time, place, and manner of performance, who neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds out as being able to obtain any Government contract or contracts through improper influence. "Contingent fee", as used in this clause, means any commission, percentage, brokerage, or other fee that is contingent upon the success that a person or concern has in securing a Government contract. "Improper influence," as used in this clause, means any influence that induces or tends to induce a Government employee or officer to give considera-

tion or to act regarding a Government contract on any basis other than the merits of the matter.

SECTION 5.5
ANTI-KICKBACK PROCEDURES (JUL 1995) (FAR 52.203-7)

(a) Definitions.

"Kickback," as used in this clause, means any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided, directly or indirectly, to any prime Contractor, prime Contractor employee, subcontractor, or subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contract or in connection with a subcontract relating to a prime contract.

"Person," as used in this clause, means a corporation, partnership, business association of any kind, trust, joint-stock company, or individual.

"Prime contract," as used in this clause, means a contract or contractual action entered into by the United States for the purpose of obtaining supplies, materials, equipment, or services of any kind.

"Prime Contractor," as used in this clause, means a person who has entered into a prime contract with the United States.

"Prime Contractor employee," as used in this clause, means any officer, partner, employee, or agent of a prime Contractor.

"Subcontract," as used in this clause, means a contract or contractual action entered into by a prime Contractor or subcontractor for the purpose of obtaining supplies, materials, equipment, or services of any kind under a prime contract.

"Subcontractor," as used in this clause, (1) means any person, other than the prime Contractor, who offers to furnish or furnishes any supplies, materials, equipment, or services of any kind under a prime contract or a subcontract entered into in connection with such prime contract, and (2) includes any person who offers to furnish or furnishes general supplies to the prime Contractor or a higher tier subcontractor.

"Subcontractor employee," as used in this clause, means any officer, partner, employee, or agent of a subcontractor.

(b) The Anti-Kickback Act of 1986 (41 U.S.C. 51-58) (the Act), prohibits any person from--

(1) Providing or attempting to provide or offering to provide any kickback;

(2) Soliciting, accepting, or attempting to accept any kickback; or

(3) Including, directly or indirectly, the amount of any kickback in the contract price charged by a prime Contractor to the United States or in the contract price charged by a subcontractor to a prime Contractor or higher tier subcontractor.

(c)(1) The Contractor shall have in place and follow reasonable procedures designed to prevent and detect possible violations described in paragraph (b) of this clause in its own operations and direct business relationships.

(2) When the Contractor has reasonable grounds to believe that a violation described in paragraph (b) of this clause may have occurred, the Contractor shall promptly report in writing the possible violation, Such reports shall be made to the inspector

general of the contracting agency, the head of the contracting agency if the agency does not have an inspector general, or the Department of Justice.

(3) The Contractor shall cooperate fully with any Federal agency investigating a possible violation described in paragraph (b) of this clause.

(4) The Contracting Officer may (i) offset the amount of the kickback against any monies owed by the United States under the prime contract and/or (ii) direct that the Prime Contractor withhold, from sums owed a subcontractor under the prime contract, the amount of any kickback. The Contracting Officer may order the monies withheld under subdivision (c)(4)(ii) of this clause be paid over to the Government unless the Government has already offset those monies under subdivision (c)(4)(i) of this clause, In either case, the Prime Contractor shall notify the Contracting Officer when the monies are withheld.

(5) The Contractor agrees to incorporate the substance of this clause, including this subparagraph (c)(5) but excepting subparagraph (c)(1), in all subcontracts under this contract which exceed $100,000.

SECTION 5.6
[RESERVED]

SECTION 5.7
AUDIT AND RECORDS-NEGOTIATION (JUN 1999) (FAR 52.215-2)

(a) As used in this clause, "records" includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form.

(b) *Examination of costs.* If this is a cost- reimbursement, incentive, time-and-materials, labor-hour or price redeterminable contract, or any combination of these, the Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all records and other evidence sufficient to reflect properly all costs claimed to have been incurred or anticipated to be incurred directly or indirectly in performance of this contract. This right of examination shall include inspection at all reasonable times of the Contractor's plants, or parts of them, engaged in performing the contract.

(c) *Cost or pricing data.* If the Contractor has been required to submit cost or pricing data in connection with any pricing action relating to this contract, the Contracting Officer, or an authorized representative of the Contracting Officer, in order to evaluate the accuracy, completeness, and currency of the cost or pricing data, shall have the right to examine and audit all of the Contractor's records, including computations and projections, related to--

(1) The proposal for the contract, subcontract, or modification;

(2) The discussions conducted on the proposal(s), including those related to negotiating;

(3) Pricing of the contract, subcontract, or modification; or

(4) Performance of the contract, subcontract or modification.

(d) *Comptroller General* — (1) The Comptroller General of the United States, or an authorized representative, shall have access to and the right to examine any of the Contractor's directly pertinent records

involving transactions related to this contract or a subcontract hereunder.

(2) This paragraph may not be construed to require the Contractor or subcontractor to create or maintain any record that the Contractor or subcontractor does not maintain in the ordinary course of business or pursuant to a provision of law.

(e) *Reports.* If the Contractor is required to furnish cost, funding, or performance reports, the Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit the supporting records and materials, for the purpose of evaluating (i) The effectiveness of the Contractor's policies and procedures to produce data compatible with the objectives of these reports and (2) The data reported.

(f) *Availability.* The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence described in paragraphs (a), (b), (c), (d), and (e) of this clause, for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in Subpart 4.7, Contractor Records Retention, of the Federal Acquisition Regulation (FAR), or for any longer period required by statute or by other clauses of this contract. In addition—(1) If this contract is completely or partially terminated, the Contractor shall make available the records relating to the work terminated until 3 years after any resulting final termination settlement; and (2) The Contractor shall make available records relating to appeals under the Disputes clause or to litigation or the settlement of claims arising under or relating to this contract until such appeals, litigation, or claims are finally resolved.

(g) The Contractor shall insert a clause containing all the terms of this clause, including this paragraph (g), in all subcontracts under this contract that exceed the simplified acquisition threshold and--

(1) That are cost-reimbursement, incentive, time-and-materials, labor-hour, or price-redeterminable type or any combination of these;

(2) For which cost or pricing data are required; or

(3) That require the subcontractor to furnish reports as discussed in paragraph (e) of this clause. The clause may be altered only as necessary to identify properly the contracting parties and the Contracting Officer under the Government prime contract.

SECTION 5.8 THRU 5.13
[RESERVED]

SECTION 5.14
UTILIZATION OF SMALL BUSINESS CONCERNS[1] (MAY 2004) (FAR 52.219-8)

(a) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for ma-

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[1] Section 5.14 only applies to six plans participating in the small business pilot (none are experience-rated HMOs).

jor systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns.

(b) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.

(c) *Definitions.* As used in this contract--"HUBZone small business concern" means a small business concern that appears on the List of Qualified HUBZone Small Business Concerns maintained by the Small Business Administration. "Service-disabled veteran-owned small business concern"—

(1) Means a small business concern-

(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and

(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a veteran with

permanent and severe disability, the spouse or permanent caregiver of such veteran.

(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C, 101(16).

"Small business concern" means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto.

"Small disadvantaged business concern" means a small business concern that represents, as part of its offer that--

(1) It has received certification as a small disadvantaged business concern consistent with 13 CFR part 124, Subpart B;

(2) No material change in disadvantaged ownership and control has occurred since its certification;

(3) Where the concern is owned by one or more individuals, the net worth of each individual upon whom the certification is based does not exceed $750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and

(4) It is identified, on the date of its representation, as a certified small disadvantaged business in the database maintained by the Small Business Administration (PRO-Net).

"Veteran-owned small business concern" means a small business concern--

(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not

less than 51 percent of the stock of which is owned by one or more veterans; and

(2) The management and daily business operations of which are controlled by one or more veterans.

"Women-owned small business concern" means a small business concern--

(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.

(d) Contractors acting in good faith may rely on written representations by their subcontractors regarding their status as a small business concern, a veteran-owned small business concern, a service-disabled veteran-owned small business concern, a HUBZone small business concern, a small disadvantaged business concern, or a women-owned small business concern.

SECTION 5.15 THRU 5.16
[RESERVED]

SECTION 5.17
CONVICT LABOR (JUN 2003) (FAR 52.222-3)

(a) Except as provided in paragraph (b) of this clause, the Contractor shall not employ in the performance of this contract any person undergoing a sentence of imprisonment imposed by any court of a State, the District of Columbia, Puerto Rico, the Northern Mariana islands, American Samoa, Guam, or the U.S. Virgin Islands.

(b) The Contractor is not prohibited from employing persons-

(1) On parole or probation to work at paid employment during the term of their sentence;

(2) Who have been pardoned or who have served their terms; or

(3) Confined for violation of the laws of any of the States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, or the U.S. Virgin Islands who are authorized to work at paid employment in the community under the laws of such jurisdiction, if-

(i) The worker is paid or is in an approved work training program on a voluntary basis;

(ii) Representatives of local union central bodies or similar labor union organizations have been consulted;

(iii) Such paid employment will not result in the displacement of employed workers, or be applied in skills, crafts, or trades in which there is a surplus of available gainful labor in the locality, or impair existing contracts for services;

(iv) The rates of pay and other conditions of employment will not be less than those paid or provided for work of a similar nature in the locality in which the work is being performed; and

(v) The Attorney General of the United States has certified that the work-release laws or regulations of the jurisdiction involved are in conformity with the requirements of Executive Order 11755, as amended by Executive Orders 12608 and 12943.

SECTION 5.18
CONTRACT WORK HOURS AND SAFETY STANDARDS ACT - OVERTIME COMPENSATION (JUL 2005) (FAR 52.222-4)

(a) *Overtime requirements.* No Contractor or subcontractor employing laborers or mechanics (see Federal Acquisition Regulation 22.300) shall require or permit them to work over 40 hours in any workweek unless they are paid at least 1 and 1/2 times the basic rate of pay for each hour worked over 40 hours.

(b) *Violation: liability for unpaid wages; liquidated damages.* The responsible Contractor and subcontractor are liable for unpaid wages if they violate the terms in paragraph (a) of this clause. In addition, the Contractor and subcontractor are liable for liquidated damages payable to the Government. The Contracting Officer will assess liquidated damages at the rate of $10 per affected employee for each calendar day on which the employer required or permitted the employee to work in excess of the standard workweek of 40 hours without paying overtime wages required by the Contract Work Hours and Safety Standards Act.

(c) *Withholding for unpaid wages and liquidated damages.* The Contracting Officer will withhold from payments due under the contract sufficient funds required to satisfy any Contractor or subcontractor liabilities for unpaid wages and liquidated damages. If amounts withheld under the contract are insufficient to satisfy Contractor or subcontractor liabilities, the Contracting Officer will withhold payments from other Federal or Federally assisted contracts held by the same Contractor that are sub-

ject to the Contract work Hours and Safety Standards Act.

(d) Payrolls and basic records. (1) The Contractor and its subcontractors shall maintain payrolls and basic payroll records for all laborers and mechanics working on the contract during the contract and shall make them available to the Government until 3 years after contract completion. The records shall contain the name and address of each employee, social security number, labor classifications, hourly rates of wages paid, daily and weekly number of hours worked, deductions made, and actual wages paid. The records need not duplicate those required for construction work by Department of Labor regulations at 29 CFR 5.5(a)(3) implementing the Davis-Bacon Act.

(2) The Contractor and its subcontractors shall allow authorized representatives of the Contracting Officer or the Department of Labor to inspect, copy, or transcribe records maintained under paragraph (d)(1) of this clause. The Contractor or subcontractor also shall allow authorized representatives of the Contracting Officer or Department of Labor to interview employees in the workplace during working hours.

(e) Subcontracts. The Contractor shall insert the provisions set forth in paragraphs (a) through (d) of this clause in subcontracts that may require or involve the employment of laborers and mechanics and require subcontractors to include these provisions in any such lower tier subcontracts. The Contractor shall be responsible for compliance by any subcontractor or lower-tier subcontractor with the provisions set forth in paragraphs (a) through (d) of this clause.

SECTION 5.19
EQUAL OPPORTUNITY (APR 2002) (FAR 52.222-26)

(a) Definition. United States, us used in this clause, means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(b) If, during any 12-month period (including the 12 months preceding the award of this contract), the Contractor has been or is awarded nonexempt Federal contracts and/or subcontracts that have an aggregate value in excess of $10,000, the Contractor shall comply with subparagraphs (b)(1) through (b)(11) of this clause, except for work performed outside the United States by employees who were not recruited within the United States, Upon request, the Contractor shall provide information necessary to determine the applicability of this clause.

(1) The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. However, it shall not be a violation of this clause for the Contractor to extend a publicly announced preference in employment to Indians living on or near an Indian reservation, in connection with employment opportunities on or near an Indian reservation, as permitted by 41 CFR 60-1.5.

(2) The Contractor shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, or national origin. This shall include, but not be limited to--

(i) Employment;

(ii) Upgrading;

(iii) Demotion;

(iv) Transfer;

(v) Recruitment or recruitment advertising;

(vi) Layoff or termination;

(vii) Rates of pay or other forms of compensation; and

(viii) Selection for training, including apprenticeship.

(3) The Contractor shall post in conspicuous places available to employees and applicants for employment the notices to be provided by the Contracting Officer that explain this clause.

(4) The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, or national origin.

(5) The Contractor shall send, to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, the notice to be provided by the Contracting Officer advising the labor union or workers' representative of the Contractor's commitments under this clause, and post copies of the notice in conspicuous places available to employees and applicants for employment.

(6) The Contractor shall comply with Executive Order 11246, as amended, and the rules, regulations, and orders of the Secretary of Labor.

(7) The Contractor shall furnish to the contracting agency all information required by Executive Order 11246, as amended, and by the rules, regulations, and orders of the Secretary of Labor. The Contractor shall also file Standard Form 100 (EEO-1), or any successor forms as prescribed in 41 CFR part 60-1. Unless the Contractor has filed within the 12 months preceding the date of contract award, the Contractor shall, within 30 days after contract award, apply to either the regional Office of Federal Contract Compliance Programs (OFCCP) or the local office of the Equal Employment Opportunity Commission for the necessary forms.

(8) The Contractor shall permit access to its premises, during normal business hours, by the contracting agency or the OFCCP for the purpose of conducting on-site compliance evaluations and complaint investigations. The Contractor shall permit the Government to inspect and copy any books, accounts, records (including computerized records), and other material that may be relevant to the matter under investigation and pertinent to compliance with Executive Order 11246, as amended, and rules and regulations that implement the Executive Order.

(9) If the OFCCP) determines that the Contractor is not in compliance with this clause or any rule, regulation., or order of the Secretary of Labor, this contract may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts, under the procedures authorized in Executive Order 11246, as amended. In addition, sanctions may be imposed and remedies invoked against the Contractor as provided in Executive Order 11246, as amend-

ed; in the rules, regulations, and orders of the Secretary of Labor; or as otherwise provided by law.

(10)The Contractor shall include the terms and conditions of subparagraphs (b)(1) through (11) of this clause in every subcontract or purchase order that is not exempted by the rules, regulations, or orders of the Secretary of Labor issued under Executive Order 11246, as amended, so that these terms and conditions will be binding upon each subcontractor or vendor.

(11)The Contractor shall take such action with respect to any subcontract or purchase order as the Contracting Officer may direct as a means of enforcing these terms and conditions, including sanctions for noncompliance, provided, that if the Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of any direction, the Contractor may request the United States to enter into the litigation to protect the interests of the United States.

(c) Notwithstanding any other clause in this contract, disputes relative to this clause will be governed by the procedures in 41 CFR 60-1.1.

SECTION 5.20
[RESERVED]

SECTION 5.21
NOTIFICATION OF VISA DENIAL (JUN 2003)
(FAR 52.222-29)

It is a violation of Executive Order 11246 for a Contractor to refuse to employ any applicant or not to assign any person hired in the United States, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, or Wake Island, on the basis that the individual's race, color,

religion, sex, or national origin is not compatible with the policies of the country where or for whom the work will be performed (41 CFR 60-1.10). The Contractor shall notify the U.S. Department of State, Assistant Secretary, Bureau of Political-Military Affairs (PM), 2201 C Street NW, Room 6212, Washington, DC 20520, and the U.S. Department of Labor, Deputy Assistant Secretary for Federal Contract Compliance, when it has knowledge of any employee or potential employee being denied an entry visa to a country where this contract will be performed, and it believes the denial is attributable to the race, color, religion, sex, or national origin of the employee or potential employee.

SECTION 5.22
EQUAL OPPORTUNITY FOR SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (DEC 2001) (FAR 52.222-35)

(a) *Definitions.* As used in this clause—

"All employment openings" means all positions except executive and top management, those positions that will be filled from within the Contractor's organization, and positions lasting 3 days or less. This term includes full-time employment, temporary employment of more than 3 days duration, and part-time employment.

"Executive and top management" means any employee—

(1) Whose primary duty consists of the management of the enterprise in which the individual is employed or of a customarily recognized department or subdivision thereof;

(2) Who customarily and regularly directs the work of two or more other employees;

(3) Who has the authority to hire or fire other employees or whose suggestions and recommendations as to the hiring or firing and as to the advancement and promotion or any other change of status of other employees will be given particular weight;

(4) Who customarily and regularly exercises discretionary powers; and

(5) Who does not devote more than 20 percent or, in the case of an employee of a retail or service establishment, who does not devote more than 40 percent of total hours of work in the work week to activities that are not directly and closely related to the performance of the work described in paragraphs (1) through (4) of this definition. This paragraph (5) does not apply in the case of an employee who is in sole charge of an establishment or a physically separated branch establishment, or who owns at least a 20 percent interest in the enterprise in which the individual is employed.

"Other eligible veteran" means any other veteran who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized.

"Positions that will be filled from within the Contractor's organization" means employment openings for which the Contractor will give no consideration to persons outside the Contractor's organization (including any affiliates, subsidiaries, and parent companies) and includes any openings the Contractor proposes to fill from regularly established "recall" lists. The exception does not apply to a particular

opening once an employer decides to consider applicants outside of its organization.

"Qualified special disabled veteran" means a special disabled veteran who satisfies the requisite skill, experience, education, and other job-related requirements of the employment position such veteran holds or desires, and who, with or without reasonable accommodation, can perform the essential functions of such position.

"Special disabled veteran" means—

(1) A veteran who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Department of Veterans Affairs for a disability—

(i) Rated at 30 percent or more; or

(ii) Rated at 10 or 20 percent in the case of a veteran who has been determined under 38 U.S.C. 3106 to have a serious employment handicap (i.e., a significant impairment of the veteran's ability to prepare for, obtain, or retain employment consistent with the veteran's abilities, aptitudes, and interests); or

(2) A person who was discharged or released from active duty because of a service-connected disability.

"Veteran of the Vietnam era" means a person who

(1) Served on active duty for a period of more than 180 days and was discharged or released from active duty with other than a dishonorable discharge, if any part of such active duty occurred—

(i) In the Republic of Vietnam between February 28, 1961, and May 7, 1975; or

(ii) Between August 5, 1964, and May 7, 1975, in all other cases; or

(2) Was discharged or released from active duty for a service-connected disability if any part of the active duty was performed—

(i) In the Republic of Vietnam between February 28, 1961, and May 7, 1975; or

(ii) Between August 5, 1964, and May 7, 1975, in all other cases.

(b) *General.* (1) The Contractor shall not discriminate against the individual because the individual is a special disabled veteran, a veteran of the Vietnam era, or other eligible veteran, regarding any position for which the employee or applicant for employment is qualified, The Contractor shall take affirmative action to employ, advance in employment, and otherwise treat qualified special disabled veterans, veterans of the Vietnam era, and other eligible veterans without discrimination based upon their disability or veterans' status in all employment practices such as—

(i) Recruitment, advertising, and job application procedures;

(ii) Hiring, upgrading, promotion, award of tenure, demotion, transfer, layoff, termination, right of return from layoff and rehiring;

(iii) Rate of pay or any other form of compensation and changes in compensation;

(iv) Job assignments, job classifications, organizational structures, position descriptions, lines of progression, and seniority lists;

(v) Leaves of absence, sick leave, or any other leave;

(vi) Fringe benefits available by virtue of employment, whether or not administered by the Contractor;

(vii) Selection and financial support for training, including apprenticeship, and on-the-job training under 38 U.S.C. 3687, professional meetings, conferences, and other related activities, and selection for leaves of absence to pursue training;

(viii) Activities sponsored by the Contractor including social or recreational programs; and

(ix) Any other term, condition, or privilege of employment.

(2) The Contractor shall comply with the rules, regulations, and relevant orders of the Secretary of Labor issued under the Vietnam Era Veterans' Readjustment Assistance Act of 1972 (the Act), as amended (38 U.S.C. 4211 and 4212).

(c) *Listing openings.* (1) The Contractor shall immediately list all employment openings that exist at the time of the execution of this contract and those which occur during the performance of this contract, including those not generated by this contract, and including those occurring at an establishment of the Contractor other than the one where the contract is being performed, but excluding those of independently operated corporate affiliates, at an appropriate local public employment service office of the State wherein the opening occurs. Listing employment

openings with the U.S. Department of Labor's America's Job Bank shall satisfy the requirement to list jobs with the local employment service office.

(2) The Contractor shall make the listing of employment openings with the local employment service office at least concurrently with using any other recruitment source or effort and shall involve the normal obligations of placing a bona fide job order, including accepting referrals of veterans and nonveterans. The listing of employment openings does not require hiring any particular job applicant or hiring from any particular group of job applicants and is not intended to relieve the Contractor from any requirements of Executive orders or regulations concerning nondiscrimination in employment.

(3) Whenever the Contractor becomes contractually bound to the listing terms of this clause, it shall advise the State public employment agency in each State where it has establishments of the name and location of each hiring location in the State. As long as the Contractor is contractually bound to these terms and has so advised the State agency, it need not advise the State agency of subsequent contracts. The Contractor may advise the State agency when it is no longer bound by this contract clause.

(d) *Applicability.* This clause does not apply to the listing of employment openings that occur and are filled outside the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Virgin Islands of the United States, and Wake Island.

(e) *Postings.* (1) The Contractor shall post employment notices in conspicuous places that are

available to employees and applicants for employment.

(2) The employment notices shall--

(i) state the rights of applicants and employees as well as the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified employees and applicants who are special disabled veterans, veterans of the Vietnam era, and other eligible veterans; and

(ii) Be in a form prescribed by the Deputy Assistant Secretary for Federal Contract Compliance Programs, Department of Labor (Deputy Assistant Secretary of Labor), and provided by or through the Contracting Officer.

(3) The Contractor shall ensure that applicants or employees who are special disabled veterans are informed of the contents of the notice (i.e., the Contractor may have the notice read to a visually disabled veteran, or may lower the posted notice so that it can be read by a person in a wheelchair).

(4) The Contractor shall notify each labor union or representative of workers with which it has a collective bargaining agreement, or other contract understanding, that the Contractor is bound by the terms of the Act and is committed to take affirmative action to employ, and advance in employment, qualified special disabled veterans, veterans of the Vietnam era, and other eligible veterans.

(f) *Noncompliance.* If the Contractor does not comply with the requirements of this clause, the Government may take appropriate actions under the rules, regulations, and relevant orders of the Secretary of Labor issued pursuant to the Act.

(g) *Subcontracts.* The *Contractor* shall insert the terms of this clause in all subcontracts or purchase orders of $25,000 or more unless exempted by rules, regulations, or orders of the Secretary of Labor. The Contractor shall act as specified by the Deputy Assistant Secretary of Labor to enforce the terms, including action for noncompliance.

SECTION 5.23
AFFIRMATIVE ACTION FOR WORKERS WITH DISABILITIES (MN 1990 (FAR 52.222-36)

(a) General. (1) Regarding any position for which the employee or applicant for employment is qualified, the Contractor shall not discriminate against any employee or applicant because of physical or mental disability. The Contractor agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified individuals with disabilities without discrimination based upon their physical or mental disabilities in all employment practices such as--

(i) Recruitment. Advertising, and job application procedures;

(ii) Hiring upgrading, promotion, award of tenure, demotion, transfer, layoff, termination, right of return from layoff, and rehiring;

(iii) Rates of pay or any other form of compensation and changes in compensation;

(iv) Job assignments, job classifications, organizational structures, position descriptions, lines of progression, and seniority lists;

(v) Leaves of absence, sick leave, or any other leave;

(vi) Fringe benefits available by virtue of employment, whether or not administered by the Contractor;

(vii) Selection and financial support for training, including apprenticeships, professional meetings, conferences, and other related activities, and selection for leaves of absence to pursue training;

(viii) Activities sponsored by the Contractor, including social or recreational programs; and

(ix) Any other term, condition, or privilege of employment.

(2) The Contractor agrees to comply with the rules, regulations, and relevant orders of the Secretary of Labor (Secretary) issued under the Rehabilitation Act of 1973 (29 U.S.C. 793) (the Act), as amended.

(b) *Postings.* (1) The Contractor agrees to post employment notices stating (i) the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified individuals with disabilities; and (ii) the rights of applicants and employees.

(2) These notices shall be posted in conspicuous places that are available to employees and applicants for employment. The Contractor shall ensure that applicants and employees with disabilities are informed of the contents of the notice (e.g., the Contractor may have the notice read to a visually disabled individual, or may lower the posted notice so that it might be read by a person in a wheelchair). The notices shall be in a form prescribed by the Deputy Assistant Secretary for Federal Contract Compliance of the U.S. Department of Labor (Deputy As-

sistant Secretary), and shall be provided by or through the Contracting Officer.

(3) The Contractor shall notify each labor union or representative of workers with which it has a collective bargaining agreement or other contract understanding, that the Contractor is bound by the terms of Section 503 of the Act and is committed to take affirmative action to employ, and advance in employment, qualified individuals with physical or mental disabilities.

(c) *Noncompliance.* If the Contractor does not comply with the requirements of this clause, appropriate actions may be taken under the rules, regulations, and relevant orders of the Secretary issued pursuant to the Act.

(d) *Subcontracts.* The Contractor shall include the terms of this clause in every subcontract or purchase order in excess of $10,000 unless exempted by rules, regulations, or orders of the Secretary. The Contractor shall act as specified by the Deputy Assistant Secretary to enforce the terms, including action for noncompliance.

SECTION 5.24
[RESERVED]

SECTION 5.25
DRUG-FREE WORKPLACE (MAY 2001) (FAR 52.223-6)

(a) Definitions. As used in this clause,

"Controlled substance" means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in regulation at 21 CPR 1308.11-1308.15.

"Conviction" means a finding of guilt (including a plea of no lo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

"Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession or use of any controlled substance.

"Drug-free workplace" means the site(s) for the performance of work done by the Contractor in connection with a specific contract where employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

"Employee" means an employee of a Contractor directly engaged in the performance of work under a Government contract. Directly engaged is defined to include all direct cost employees and any other Contractor employee who has other than a minimal impact or involvement in contract performance.

"Individual" means an offeror/contractor that has no more than one employee including the offeror/contractor.

(b) The Contractor, if other than an individual, shall - within 30 days after award (unless a longer period is agreed to in writing for contracts of 30 days or more performance duration); or as soon as possible for contracts of less than 30 days performance duration-

(1) Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the contractor's workplace and speci-

fying the actions that will be taken against employees for violations of such prohibition;

(2) Establish an ongoing drug-free awareness program to inform such employees about-

(i) The dangers of drug abuse in the workplace;

(ii) The contractor's policy of maintaining a drug-free workplace;

(iii) Any available drug counseling, rehabilitation, and employee assistance programs; and

(iv) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

(3) Provide all employees engaged in performance of the contract with a copy of the statement required by subparagraph (b)(1) of this clause;

(4) Notify such employees in writing in the statement required by subparagraph (b)(1) of this clause that, as a condition of continued employment on this contract, the employee will-

(i) Abide by the terms of the statement; and

(ii) Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than 5 days after such conviction.

(5) Notify the Contracting Officer in writing within 10 days after receiving notice under subdivision (b)(4)(ii) of this clause, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee;

(6) Within 30 days after receiving notice under subdivision (b)(4)(ii) of this clause of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:

(i) Taking appropriate personnel action against such employee, up to and including termination; or

(ii) Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(7) Make a good faith effort to maintain a drug-free workplace through implementation of subparagraphs (b)(l) through (b)(6) of this clause.

(c) The Contractor, if an individual, agrees by award of the contract or acceptance of a purchase order, not to engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while performing this contract.

(d) In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (b) or (c) of this clause may, pursuant to FAR 23.506, render the Contractor subject to suspension of contract payments, termination of the contract for default, and suspension or debarment.

SECTION 5.26
FEDERAL, STATE, AND LOCAL TAXES (STATE AND LOCAL ADJUSTMENTS) (APR 2003) (FAR 52.229-3)

(a) As used in this clause-

"After-imposed tax" means any new or increased Federal, State, or local tax or duty, or tax that was excluded on the contract date but whose exclusion was later revoked or amount of exemption reduced during the contract period, other than an excepted tax, on the transactions or property covered by this contract that the Contractor is required to pay or bear as the result of legislative, judicial, or administrative action taking effect after the contract date.

"After-relieved tax" means any amount of Federal, State, or local tax or duty, other than an excepted tax, that would otherwise have been payable on the transactions or property covered by this contract, but which the Contractor is not required to pay or bear, or for which the Contractor obtains a refund or drawback, as the result of legislative, judicial, or administrative action taking effect after the contract date.

"All applicable Federal, State, and local taxes and duties" means all taxes and duties, in effect on the contract date, that the taxing authority is imposing and collecting on the transactions or property covered by this contract.

"Contract date" means the effective date of this contract and, for any modification to this contract, the effective date of the modification.

"Excepted tax" means social security or other employment taxes, net income and franchise taxes, excess profits taxes, capital stock taxes, transportation taxes, unemployment compensation taxes, and property taxes. "Excepted tax" does not include gross income taxes levied on or measured by sales or receipts from sales, property taxes assessed on completed supplies covered by this contract, or any tax

assessed on the Contractor's possession of, interest in, or use of property, title to which is in the Government.

"Local taxes" includes taxes imposed by a possession or territory of the United States, Puerto Rico, or the Northern Mariana Islands, if the contract is performed wholly or partly in any of those areas.

(b) Unless otherwise provided in this contract, the contract price includes all applicable Federal, State, and local taxes and duties.

(c) The contract price shall be increased by the amount of any after-imposed tax, or of any tax or duty specifically excluded from the contract price by a term or condition of this contract that the Contractor is required to pay or bear, including any interest or penalty, if the Contractor states in writing that the contract price does not include any contingency for such tax and if liability for such tax, interest, or penalty was not incurred through the Contractor's fault, negligence, or failure to follow instructions of the Contracting Officer.

(d) The contract price shall be decreased by the amount of any after-relieved tax. The Government shall be entitled to interest received by the Contractor incident to a refund of taxes to the extent that such interest was earned after the Contractor was paid by the Government for such taxes, The Government shall be entitled to repayment of any penalty refunded to the Contractor to the extent that the penalty was paid by the Government.

(e) The contract price shall be decreased by the amount of any Federal, State, or local tax, other than an excepted tax, that was included in the contract price and that the Contractor is required to pay or

bear, or does not obtain a refund of, through the Contractor's fault, negligence, or failure to follow instructions of the Contracting Officer.

(f) No adjustment shall be made in the contract price under this clause unless the amount of the adjustment exceeds $250.

(g) The Contractor shall promptly notify the Contracting Officer of all matters relating to Federal, State, and local taxes and duties that reasonably may be expected to result in either an increase or decrease in the contract price and shall take appropriate action as the Contracting Officer directs. The contract price shall be equitably adjusted to cover the costs of action taken by the Contractor at the direction of the Contracting Officer, including any interest, penalty, and reasonable attorneys' fees.

(h) The Government shall furnish evidence appropriate to establish exemption from any Federal, State, or local tax when-

(1) The Contractor requests such exemption and states in writing that it applies to a tax excluded from the contract price; and

(2) A reasonable basis exists to sustain the exemption.

SECTION 5.27
[RESERVED]

SECTION 5.28
RESERVED

SECTION 5.29
TAXES - FOREIGN NEGOTIATED BENEFITS CON-TRACTS (JAN 1998) (FEHMAR 1652.229-70)

(a) To the extent that this contract provides for performing services outside the United States, its possessions, and Puerto Rico, this clause applies in lieu of any Federal, State, and local taxes clause of the contract.

(b) "Contract date," as used in this clause, means the effective date of this contract or modification.

"Country concerned," as used in this clause, means any country, other than the United States, its possessions, and Puerto Rico, in which expenditures under this contract are made.

"Tax" and "taxes," as used in this clause, include fees and charges for doing business that are levied by the government of the country concerned or by its political subdivisions.

"All applicable taxes and duties," as used in this clause, means all taxes and duties, in effect on the contract date, that the taxing authority is imposing and collecting on the transactions covered by this contract, pursuant to written ruling or regulation in effect on the contract date, "After-imposed tax," as used in this clause, means any new or increased tax or duty, or tax that was exempted or excluded on the contract date but whose exemption was later revoked or reduced during the contract period, other than excepted tax, on the transactions covered by this contract that the Carrier is required to pay or bear as the result of legislative, judicial, or administrative action taking effect after the contract date.

"After-relieved tax," as used in this clause, means any amount of tax or duty, other than an excepted tax, that would otherwise have been payable on the transactions covered by this contract, but which the Carrier is not required to pay or bear, or for which the Carrier obtains a refund, as the result of legislative, judicial, or administrative action taking effect after the contract date.

"Excepted tax," as used in this clause, means social security or other employment taxes, net income and franchise taxes, excess profits taxes, capital stock taxes, transportation taxes, unemployment compensation taxes, and property taxes. "Excepted tax" does not include gross income taxes levied on or measured by sales or receipts from sales covered by this contract, or any tax assessed on the Carrier's possession of, interest in, or use of property, title to which is in the U.S. Government.

(c) Unless otherwise provided in this contract, the contract price includes all applicable taxes and duties, except taxes and duties that the Government of the United States and the government of the country concerned have agreed shall not be applicable to expenditures in such country by or on behalf of the United States.

(d) The contract price shall be increased by the amount of any after-imposed tax or of any tax or duty specifically excluded from the contract price by a provision of this contract that the Carrier is required to pay or bear, including any interest or penalty, if the Carrier states in writing that the contract price does not include any contingency for such tax and if liability for such tax, interest, or penalty was not incurred through the Carrier's fault, negligence, or failure to follow instructions of the Contracting Of-

ficer or to comply with the provisions of paragraph (i) below.

(e) The contract price shall be decreased by the amount of any after-relieved tax, including any interest or penalty. The Government of the United States shall be entitled to interest received by the Carrier incident to a refund of taxes to the extent that such interest was earned after the Carrier was paid by the Government of the United States for such taxes. The Government of the United States shall be entitled to repayment of any penalty refunded to the Carrier to the extent that the penalty was paid by the Government.

(f) The contract price shall be decreased by the amount of any tax or duty, other than an excepted tax, that was included in the contract and that the Carrier is required to pay or bear, or does not obtain a refund of, through the Carrier's fault, negligence, or failure to follow instructions of the Contracting Officer or to comply with the provisions of paragraph (i) below.

(g) No adjustment shall be made in the contract price under this clause unless the amount of the adjustment exceeds $250.

(h) If the Carrier obtains a reduction in tax liability under the United States Internal Revenue Code (Title 26, U.S. Code) because of the payment of any tax or duty that either was included in the contract price or was the basis of an increase in the contract price, the amount of the reduction shall be paid or credited to the Government of the United States as the Contracting Officer directs.

(i) The Carrier shall take all reasonable action to obtain exemption from or refund of any taxes or

duties, including interest or penalty, from which the United States Government, the Carrier, any subcontractor, or the transactions covered by this contract are exempt under the laws of the country concerned or its political subdivisions or which the governments of the United States and of the country concerned have agreed shall not be applicable to expenditures in such country by or on behalf of the United States.

(j) The Carrier shall promptly notify the Contracting Officer of all matters relating to taxes or duties that reasonably may be expected to result in either an increase or decrease in the contract price and shall take appropriate action as the Contracting Officer directs. The contract price shall be equitably adjusted to cover the costs of action taken by the Carrier at the direction of the Contracting Officer, including any interest, penalty, and reasonable attorneys' fees.

SECTION 5.30
COST ACCOUNTING STANDARDS (APR 1998)
(FAR 52.230-2)

(a) Unless the contract is exempt under 48 CFR 9903.201-1 and 9903.201-2, the provisions of 48 CFR Part 9903 are incorporated herein by reference and the Contractor, in connection with this contract, shall -

(1) (CAS-covered Contracts Only) By submission of a Disclosure Statement, disclose in writing the Contractor's cost accounting practices as required by 48 CFR-9903.202-1 through 9903.202-5, including methods of distinguishing direct costs from indirect costs and the basis used for allocating indirect costs, The practices disclosed for this contract shall be the same as the practices currently disclosed and applied

on all other contracts and subcontracts being performed by the Contractor and which contain a Cost Accounting Standards (CAS) clause. If the Contractor has notified the Contracting Officer that the Disclosure Statement contains trade secrets and commercial or financial information which is privileged and confidential, the Disclosure Statement shall be protected and shall not be released outside of the Government.

(2) Follow consistently the Contractor's cost accounting practices in accumulating and reporting contract performance cost data concerning this contract. If any change in cost accounting practices is made for the purposes of any contract or subcontract subject to CAS requirements, the change must be applied prospectively to this contract and the Disclosure Statement must be amended accordingly. If the contract price or cost allowance of this contract is affected by such changes, adjustment shall be made in accordance with subparagraph (a)(4) or (a)(5) of this clause, as appropriate.

(3) Comply with all CAS, including any modifications and interpretations indicated thereto contained in 48 CFR Part 9904, in effect on the date of award of this contract or, if the Contractor has submitted cost or pricing data, on the date of final agreement on price as shown on the Contractor's signed certificate of current cost or pricing data, The Contractor shall also comply with any CAS (or modifications to CAS) which hereafter become applicable to a contract or subcontract of the Contractor. Such compliance shall be required prospectively from the date of applicability to such contract or subcontract.

(4)(i) Agree to an equitable adjustment as provided in the Changes clause of this contract if the

contract cost is affected by a change which, pursuant to subparagraph (a)(3) of this clause, the Contractor is required to make to the Contractor's established cost accounting practices.

(ii) Negotiate with the Contracting Officer to determine the terms and conditions under which a change may be made to a cost accounting practice, other than a change made under other provisions of subparagraph (a)(4) of this clause; provided that no agreement may be made under this provision that will increase costs paid by the United States.

(iii) When the parties agree to a change to a cost accounting practice, other than a change under subdivision (a)(4)(i) of this clause, negotiate an equitable adjustment as provided in the Changes clause of this contract.

(5) Agree to an adjustment of the contract price or cost allowance, as appropriate, if the Contractor or a subcontractor fails to comply with an applicable Cost Accounting Standard, or to follow any cost accounting practice consistently and such failure results in any increased costs paid by the United States. Such adjustment shall provide for recovery of the increased costs to the United States, together with interest thereon computed at the annual rate established under section 6621 of the Internal Revenue Code of 1986 (26 U.S.C. 6621) for such period, from the time the payment by the United States was made to the time the adjustment is effected. In no case shall the Government recover costs greater than the increased cost to the Government, in the aggregate, on the relevant contracts subject to the price adjustment, unless the Contractor made a change in its cost accounting practices of which it was aware or should have been aware at the time of price negotia-

tions and which it failed to disclose to the Government.

(b) If the parties fail to agree whether the Contractor or a subcontractor has complied with an applicable CAS in 48 CFR Part 9904 or a CAS rule or regulation in 48 CPR Part 9903 and as to any cost adjustment demanded by the United States, such failure to agree will constitute a dispute under the Contract Disputes Act (41 U.S.C. 601).

(c) The Contractor shall permit any authorized representatives of the Government to examine and make copies of any documents, papers, or records relating to compliance with the requirements of this clause.

(d) The Contractor shall include in all negotiated subcontracts which the Contractor enters into, the substance of this clause, except paragraph (b), and shall require such inclusion in all other subcontracts, of any tier, including the obligation to comply with all CAS in effect on the subcontractor's award date or if the subcontractor has submitted cost or pricing data, on the date of final agreement on price as shown on the subcontractor's signed Certificate of Current Cost or Pricing Data. If the subcontract is awarded to a business unit which pursuant to 48 CFR 9903.201-2 is subject to other types of CAS coverage, the substance of the applicable clause set forth in subsection 30.201-4 of the Federal Acquisition Regulation shall be inserted. This requirement shall apply only to negotiated subcontracts in excess of $500,000, except that the requirement shall not apply to negotiated subcontracts otherwise exempt from the requirement to include a CAS clause as specified in 48 CFR 9903.201-1.

SECTION 5.31
DISCLOSURE AND CONSISTENCY OF COST ACCOUNTING PRACTICES (APR 1998) (FAR 52.230-3)

(a) The Contractor, in connection with this contract, shall -

(1) Comply with the requirements of 48 CFR 9904.401, Consistency in Estimating, Accumulating, and Reporting Costs, 48 CFR 9904.402, Consistency in Allocating Costs Incurred for the Same Purpose; 48 CFR 9904.405, Accounting for Unallowable Costs; and 48 CFR 9904.406 Cost Accounting Standard--Cost Accounting Period, in effect on the date of award of this contract as indicated in 48 CFR Part 9904.

(2) (CAS-covered Contracts Only) If it is a business unit of a company required to submit a Disclosure Statement, disclose in writing its cost accounting practices as required by 48 CFR 9903.202-1 through 9903.202-5. If the Contractor has notified the Contracting Officer that the Disclosure Statement contains trade secrets and commercial or financial information which is privileged and confidential, the Disclosure Statement shall be protected and shall not be released outside of the Government.

(3)(i) Follow consistently the Contractor's cost accounting practices. A change to such practices may be proposed, however, by either the Government or the Contractor, and the Contractor agrees to negotiate with the Contracting Officer the terms and conditions under which a change may be made. After the terms and conditions under which the change is to be made have been agreed to, the change must be applied prospectively to this contract, and the Disclo-

sure Statement, if affected, must be amended accordingly.

(ii) The Contractor shall, when the parties agree to a change to a cost accounting practice and the Contracting Officer has made the finding required in 48 CFR 9903.201-6(b), that the change is desirable and not detrimental to the interests of the Government, negotiate an equitable adjustment as provided in the Changes clause of this contract with the absence of the required finding, no agreement may be made under this contract clause that will increase costs paid by the United States.

(4) Agree to an adjustment of the contract price or cost allowance, as appropriate, if the Contractor or a subcontractor fails to comply with the applicable CAS or to follow any cost accounting practice, and such failure results in any increased costs paid by the United States. Such adjustment shall provide for recovery of the increased costs to the United States together with interest thereon computed at the annual rate of interest established under the Internal Revenue Code of 1986 (26 U.S.C. 6621), from the time the payment by the United States was made to the time the adjustment is effected.

(b) If the parties fail to agree whether the Contractor has complied with an applicable CAS, rule, or regulation as specified in 48 CFR Parts 9903 and 9904 and as to any cost adjustment demanded by the United States, such failure to agree will constitute a dispute under the Contract Disputes Act (41 U.S.C. 601).

(c) The Contractor shall permit any authorized representatives of the Government to examine and make copies of any documents, papers, and records

relating to compliance with the requirements of this clause.

(d) The Contractor shall include in all negotiated subcontracts, which the Contractor enters into, the substance of this clause, except paragraph (b), and shall require such inclusion in all other subcontracts of any tier, except that -

(1) If the subcontract is awarded to a business unit which pursuant to 48 CFR 9903.201 or 9903.201-2 is subject to other types of CAS coverage, the substance of the applicable clause set forth in subsection 30.201-4 of the Federal Acquisition regulation shall be inserted.

(2) This requirement shall apply only to negotiated subcontracts in excess of $500,000.

(3) The requirement shall not apply to negotiated subcontracts otherwise exempt from the requirement to include a CAS clause as specified in 48 CFR 9903.201-1.

SECTION 5.32
RESERVED

SECTION 5.33
DISCOUNTS FOR PROMPT PAYMENT (FEB 2002)
(FAR 52.232-8)

(a) Discounts for prompt payment will not be considered in the evaluation of offers. However, any offered discount will form a part of the award, and will be taken if payment is made within the discount period indicated in the offer by the offeror. As an alternative to offering a discount for prompt payment in conjunction with the offer, offerors awarded contracts may include discounts for prompt payment on individual invoices.

(b) In connection with any discount offered for prompt payment, time shall be imputed from the date of the invoice. If the Contractor has not placed a date on the invoice, the due date shall be calculated from the date the designated billing office receives a proper invoice, provided the agency annotates such invoice with the date of receipt at the time of receipt. For the purpose of computing the discount earned, payment shall be considered to have been made on the date that appears on the payment check or, for an electronic funds transfer, the specified payment date. When the discount date falls on a Saturday, Sunday, or legal holiday when Federal Government offices are closed and Government business is not expected to be conducted, payment may be made on the following business day.

SECTION 5.34
INTEREST (JUN 1996) (FAR 52.232-17) FEHBAR (JAN 1995)

(a) Except as otherwise provided in this contract under a Price Reduction for Defective Cost or Pricing Data clause or a Cost Accounting Standards clause, all amounts that become payable by the Contractor to the Government under this contract shall bear simple interest from the date due until paid unless paid within 30 days of becoming due. The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 12 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (b) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid.

(b) Amounts shall be due at the earliest of the following dates:

(1) The date fixed under this contract.

(2) The date of the first written demand for payment consistent with this contract, including any demand resulting from a default termination.

(3) The date the Government transmits to the Contractor a proposed supplemental agreement to confirm completed negotiations establishing the amount of debt.

(4) If this contract provides for revision of prices, the date of written notice to the Contractor stating the amount of refund payable in connection with a pricing proposal or a negotiated pricing agreement not confirmed by contract modification.

(c) The interest charge made under this clause may be reduced under the procedures prescribed in 32.614-2 of the Federal Acquisition Regulation in effect on the date of this contract.

SECTION 5.35
ASSIGNMENT OF CLAIMS (JAN 1986) (FAR 52.232-23)

(a) The Contractor, under the Assignment of Claims Act, as amended, 31 U.S.C. 3727, 41 U.S.C. 15 (hereafter referred to as "the Act"), may assign its rights to be paid amounts due or to become due as a result of the performance of this contract to a bank, trust company, or other financing institution, including any Federal lending agency. The assignee under such an assignment may thereafter further assign or reassign its right under the original assignment to any type of financing institution described in the preceding sentence.

(b) Any assignment or reassignment authorized under the Act and this clause shall cover all unpaid amounts payable under this contract, and shall not be made to more than one party, except that an assignment or reassignment may be made to one party as agent or trustee for two or more parties participating in the financing of this contract.

(c) The Contractor shall not furnish or disclose to any assignee under this contract any classified document (including this contract) or information related to work under this contract until the Contracting Officer authorizes such action in writing.

SECTION 5.36
DISPUTES (JUL 2002) (FAR 52.233-1)

(a) This contract is subject to the Contract Disputes Act of 1978, as amended (41 U.S.C. 601-613).

(b) Except as provided in the Act, all disputes arising under or relating to this contract shall be resolved under this clause.

(c) "Claim," as used in this clause, means a written demand or written assertion by one of the contracting parties seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to this contract. However, a written demand or written assertion by the Contractor seeking the payment of money exceeding $100,000 is not a claim under the Act until certified. A voucher, invoice, or other routine request for payment that is not in dispute when submitted is not a claim under the Act. The submission may be converted to a claim under the Act, by complying with the submission and certification requirements of this

clause, if it is disputed either as to liability or amount or is not acted upon in a reasonable time.

(d)(1) A claim by the Contractor shall be made in writing and, unless otherwise stated in this contract, submitted within 6 years after accrual of the claim to the Contracting Officer for a written decision. A claim by the Government against the Contractor shall be subject to a written decision by the Contracting Officer.

(2)(i) The Contractor shall provide the certification specified in paragraph (d)(2)(iii) of this clause when submitting any claim exceeding $100,000.

(ii) The certification requirement does not apply to issues in controversy that have not been submitted as all or part of a claim.

(iii) The certification shall state as follows: "I certify that the claim is made in good faith; that the supporting data are accurate and complete to the best of my knowledge and belief; that the amount requested accurately reflects the contract adjustment for which the Contractor believes the Government is liable; and that I am duly authorized to certify the claim on behalf of the Contractor."

(3) The certification may be executed by any person duly authorized to bind the Contractor with respect to the claim. For Contractor claims of $100,000 or less, the Contracting Officer must, if requested in writing by the Contractor, render a decision within 60 days of the request.

(e) For Contractor-certified claims over $100,000, the Contracting Officer must, within 60 days, decide the claim or notify the Contractor of the date by which the decision will be made.

(f) The Contracting Officer's decision shall be final unless the Contractor appeals or files a suit as provided in the Act.

(g) If the claim by the Contractor is submitted to the Contracting Officer or a claim by the Government is presented to the Contractor, the parties, by mutual consent, may agree to use alternative dispute resolution (ADR). If the Contractor refuses an offer for ADR, the Contractor shall inform the Contracting Officer, in writing, of the Contractor's specific reasons for rejecting the offer.

(h) The Government shall pay interest on the amount found due and unpaid from (1) the date that the Contracting Officer receives the claim (certified, if required); or (2) the date that payment otherwise would be due, if that date is later, until the date of payment. With regard to claims having defective certifications, as defined in FAR 33.201, interest shall be paid from the date that the Contracting Officer initially receives the claim. Simple interest on claims shall be paid at the rate, fixed by the Secretary of the Treasury as provided in the Act, which is applicable to the period during which the Contracting Officer receives the claim and then at the rate applicable for each 6-month period as fixed by the Treasury Secretary during the pendency of the claim.

(i) The Contractor shall proceed diligently with performance of this contract, pending final resolution of any request for relief, claim, appeal, or action arising under or relating to the contract, and comply with any decision of the Contracting Officer.

SECTION 5.37
[RESERVED]

SECTION 5.38
CHANGES-- NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.243-70)

(a) The Contracting Officer may at any time, by written order, and without notice to the sureties, if any, make changes within the general scope of this contract in any one or more of the following:

(1) Description of services to be performed.

(2) Time of performance (i.e., hours of the day, days of the week, etc.).

(3) Place of performance of the services.

(b) If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, whether or not changed by the order, the Contracting Officer shall make an equitable adjustment in the contract price, the delivery schedule, or both, and shall modify the contract.

(c) The Carrier must assert its right to an adjustment under this clause within 30 days from the date of receipt of the written order. However, if the Contracting Officer decides that the facts justify it, the Contracting Officer may receive and act upon a proposal submitted before final payment of the contract.

(d) Failure to agree to any adjustment shall be a dispute under the Disputes clause. However, nothing in this clause shall excuse the Carrier from proceeding with the contract as changed.

SECTION 5.39
[RESERVED]

SECTION 5.40
GOVERNMENT PROPERTY (NEGOTIATED BENEFITS CONTRACTS) (JAN 1998) (FEHBAR 1652.245-70)

(a) Government-furnished property. (1) The Government shall deliver to the Carrier, for use in connection with and under the terms of this contract, the Government-furnished property described in this contract together with any related data and information that the Carrier may request and is reasonably required for the intended use of the property (hereinafter referred to as "Government-furnished property").

(2) The delivery or performance dates for this contract are based upon the expectation that Government-furnished property suitable for use (except for property furnished "as-is") will be delivered to the Carrier at the times stated in this contract or, if not so stated, in sufficient time to enable the Carrier to meet the contract's performance dates.

(3) If Government-furnished property is received by the Carrier in a condition not suitable for the intended use, the Carrier shall, upon receipt of it, notify the Contracting Officer, detailing the facts, and, as directed by the Contracting Officer and at Government expense, either repair, modify, return, or otherwise dispose of the property. After completing the directed action and upon written request of the Carrier, the Contracting Officer shall make an equitable adjustment as provided in paragraph (h) of this clause.

(b) Changes in Government-furnished property. (1) The Contracting Officer may, by written notice, (i) decrease the Government-furnished property pro-

vided or to be provided under this contract, or (ii) substitute other Government-furnished property for the property to be provided by the Government, or to be acquired by the Carrier for the Government, under this contract. The Carrier shall promptly take such action as the Contracting Officer may direct regarding the removal, shipment, or disposal of the properly covered by such notice.

(2) Upon the Carrier's written request, the Contracting Officer shall make an equitable adjustment to the contract in accordance with paragraph (h) of this clause, if the Government has agreed in this contract to make the property available for performing this contract and there is any -

(i) Decrease or substitution in this property pursuant to subparagraph (b) (1) above; or

(ii) Withdrawal of authority to use this property, if provided under any other contract or lease.

(c) Title in Government property. (1) The Government shall retain title to all Government-furnished property.

(2) All Government-furnished property and all property acquired by the Carrier, title to which vests in the Government under this paragraph (collectively referred to as "Government property"), are subject to the provisions of this clause. Title to Government property shall not be affected by its incorporation into or attachment to any property not owned by the Government, nor shall Government property become a fixture or lose its identity as personal property by being attached to any real property.

(d) Use of Government property, The Government property shall be used only for performing this

contract, unless otherwise provided in this contract or approved by the Contracting Officer.

(e) Property administration. (1) The Carrier shall be responsible and accountable for all Government property provided under this contract and shall comply with Federal Acquisition Regulation (FAR) subpart 45.5, as in effect on the date of this contract.

(2) The Carrier shall establish and maintain a program for the use, maintenance, repair, protection, and preservation of Government property in accordance with sound industrial practice and the applicable provisions of subpart 45.5 of the FAR.

(3) If damage occurs to Government property, the risk of which has been assumed by the Government under this contract, the Government shall replace the items or the Carrier shall make such repairs as the Government directs. However, if the Carrier cannot effect such repairs within the time required, the Carrier shall dispose of the property as directed by the Contracting Officer. When any property for which the Government is responsible is replaced or repaired, the Contracting Officer shall make an equitable adjustment in accordance with paragraph (h) of this clause.

(4) The Carrier represents that the contract price does not include any amount for repairs or replacement for which the Government is responsible. Repair or replacement of property for which the Carrier is responsible shall be accomplished by the Carrier at its own expense.

(f) Access. The Government and all its designees shall have access at all reasonable times to the premises in which any Government property is locat-

ed for the purpose of inspecting the Government property.

(g) Risk of loss. Unless otherwise provided in this contract, the Carrier assumes the risk of, and shall be responsible for, any loss or destruction of or damage to, Government property upon its delivery to the Carrier. However, the Carrier is not responsible for reasonable wear and tear to Government property or for Government property properly consumed in performing this contract.

(h) Equitable adjustment. When this clause specifies an equitable adjustment, it shall be made to any affected contract provision in accordance with the procedures of the Changes clause. When appropriate, the Contracting Officer may initiate an equitable adjustment in favor of the Government. The right to an equitable adjustment shall be the Carrier's exclusive remedy. The Government shall not be liable to suit for breach of contract for -

(1) Any delay in delivery of Government-furnished property;

(2) Delivery of Government-furnished property in a condition not suitable for its intended use;

(3) A decrease in or substitution of Government-furnished property; or

(4) Failure to repair or replace Government property for which the Government is responsible.

(i) Final accounting and disposition of Government property. Upon completing this contract, or at such earlier dates as may be fixed by the Contracting Officer, the Carrier shall submit, in a form acceptable to the Contracting Officer, inventory schedules covering all items of Government property (including

any resulting scrap) not consumed in performing this contract or delivered to the Government, The Carrier shall prepare for shipment, deliver f.o.b. origin, or dispose of the Government property as may be directed or authorized by the Contracting Officer, The net proceeds of any such disposal shall be credited to the contract price or shall be paid to the Government as the Contracting Officer directs.

(j) Abandonment and restoration of Carrier's premises. Unless otherwise provided herein, the Government-

(1) May abandon any Government property in place, at which time all obligations of the Government regarding such abandoned property shall cease; and,

(2) Has no obligation to restore or rehabilitate the Carrier's premises under any circumstances (e.g., abandonment, disposition upon completion of need, or upon contract completion). However, if the Government-furnished property is withdrawn or is unsuitable for the intended use, or if other Government property is substituted, then the equitable adjustment under paragraph (h) of this clause may properly include restoration or rehabilitation costs.

(k) Communications. All communications under this clause shall be in writing. (1) Overseas contracts. If this contract is to be performed outside of the United States of America, its territories, or possessions, the words "Government" and "Government-furnished" (wherever they appear in this clause) shall be construed as "United States Government" and "United States Government-furnished", respectively.

SECTION 5.41
[RESERVED]

SECTION 5.42
PREFERENCE FOR U.S.-FLAG AIR CARRIERS
(JUN 2003) (FAR 52.247-63)

(a) *Definitions.* As used in this clause-

"International air transportation" means transportation by air between a place in the United States and a place outside the United States or between two places both of which are outside the United States.

"United States" means the 50 States, the District of Columbia, and outlying areas.

"U.S.-flag air carrier" means an air carrier holding a certificate under 49 U.S.C. Chapter 411.

(b) Section 5 of the International Air Transportation Fair Competitive Practices Act of 1974 (49 U.S.C. 40118). (Fly America Act) requires that all Federal agencies and Government contractors and subcontractors use U.S.-flag air carriers for U.S. Government-financed international air transportation of personnel (and their personal effects) or property, to the extent that service by those carriers is available. It requires the Comptroller General of the United States, in the absence of satisfactory proof of the necessity for foreign-flag air transportation, to disallow expenditures from funds, appropriated or otherwise established for the account of the United States, for international air transportation secured aboard a foreign flag air carrier if a U.S.-flag air carrier is available to provide such services.

(c) If available, the Contractor, in performing work under this contract, shall use U.S.-flag carriers

for international air transportation of personnel (and their personal effects) or property.

(d) In the event that the Contractor selects a carrier other than a U.S.-flag air carrier for international air transportation, the Contractor shall include a statement on vouchers involving such transportation essentially as follows:

STATEMENT OF UNAVAILABILITY OF U.S. FLAG AIR CARRIERS

International air transportation of persons (and their personal effects) or property by U.S. flag air carrier was not available or it was necessary to use foreign-flag air carrier service for the following reasons (see section 47.403 of the Federal Acquisition Regulation):

(State reasons): (End of statement)

(e) The Contractor shall include the substance of this clause, including this paragraph (e), in each subcontract or purchase under this contract that may involve international air transportation.

SECTION 5.43
[RESERVED]

SECTION 5.44
AUTHORIZED DEVIATIONS IN CLAUSES (APR 1984) (FAR 52.252-6)

(a) The use in this solicitation or contract of any Federal Acquisition Regulation (48 CFR Chapter 1) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" alter the date of the clause.

(b) The use in this solicitation or contract of any Federal Employees Health Benefits Acquisition Reg-

ulation (48 CFR Chapter 16) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the name of the regulation.

SECTION 5.45
LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (JUN 2003) (FAR 52.203-12)

(a) *Definitions.*

"Agency," as used in this clause, means executive agency as defined in FAR 2.101.

"Covered Federal action," as used in this clause, means any of the following Federal actions:

(1) The awarding of any Federal contract.

(2) The making of any Federal grant.

(3) The making of any Federal loan.

(4) The entering into of any cooperative agreement.

(5) The extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

"Indian tribe" and "tribal organization," as used in this clause, have the meaning provided in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450B) and include Alaskan Natives.

"Influencing or attempting to influence," as used in this clause, means making, with the intent to influence, any communication to or appearance before an officer or employee or any agency, a Member of Congress, an officer or employee of Congress, or an

employee of a Member of Congress in connection with any covered Federal action.

"Local government," as used in this clause, means a unit of government in a State and, if chartered, established, or otherwise recognized by a State for the performance of a governmental duty, including a local public authority, a special district, an intrastate district, a council of governments, a sponsor group representative organization, and any other instrumentality of a local government.

"Officer or employee of an agency," as used in this clause, includes the following individuals who are employed by an agency:

(1) An individual who is appointed to a position in the Government under title 5, United States Code, including a position under a temporary appointment.

(2) A member of the uniformed services, as defined in subsection 101(3), title 37, United States Code.

(3) A special Government employee, as defined in section 202, title 18, United States Code.

(4) An individual who is a member of a Federal advisory committee, as defined by the Federal Advisory Committee Act, title 5, United States Code, appendix 2.

"Person," as used in this clause, means an individual, corporation, company, association, authority, firm, partnership, society, State, and local government, regardless of whether such entity is operated for profit, or not for profit. This term excludes an Indian tribe, tribal organization, or any other Indian organization with respect to expenditures specifically permitted by other Federal law.

"Reasonable compensation," as used in this clause, means, with respect to a regularly employed officer or employee of any person, compensation that is consistent with the normal compensation for such officer or employee for work that is not furnished to, not funded by, or not furnished in cooperation with the Federal Government.

"Reasonable payment," as used in this clause, means, with respect to professional and other technical services, a payment in an amount that is consistent with the amount normally paid for such services in the private sector.

"Recipient," as used in this clause, includes the Contractor and all subcontractors. This term excludes an Indian tribe, tribal organization, or any other Indian organization with respect to expenditures specifically permitted by other Federal law.

"Regularly employed," as used in this clause, means, with respect to an officer or employee of a person requesting or receiving a Federal contract, an officer or employee who is employed by such person for at least 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person for receipt of such contract. An officer or employee who is employed by such person for less than 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person shall be considered to be regularly employed as soon as he or she is employed by such person for 130 working days.

"State," as used in this clause, means a State of the United States, the District of Columbia, or an outlying area of the United States, an agency or in-

strumentality of a State, and multi-State, regional, or interstate entity having governmental duties and powers.

(b) Prohibitions.

(1) Section 1352 of title 31, United States Code, among other things, prohibits a recipient of a Federal contract, grant, loan, or cooperative agreement from using appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract; the making of any Federal grant; the making of any Federal loan; the entering into of any cooperative agreement; or the modification of any Federal contract, grant, loan, or cooperative agreement.

(2) The Act also requires Contractors to furnish a disclosure if any funds other than Federal appropriated funds (including profit or fee received under a covered Federal transaction) have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a Federal contract, grant, loan, or cooperative agreement.

(3) The prohibitions of the Act do not apply under the following conditions:

(i) *Agency and legislative liaison by own employees.*

(A) The prohibition on the use of appropriated funds, in subparagraph (b) (1) of this clause, does not

apply in the case of a payment of reasonable compensation made to an officer or employee of a person requesting or receiving a covered Federal action if the payment is for agency and legislative liaison activities not directly related to a covered Federal action.

(B) For purposes of subdivision (b)(3)(i)(a) of this clause, providing any information specifically requested by an agency or Congress is permitted at any time.

(C) The following agency and legislative liaison activities are permitted at any time where they are not related to a specific solicitation for any covered Federal action:

(1) Discussing with an agency the qualities and characteristics (including individual demonstrations) of the person's products or services, conditions or terms of sale, and service capabilities.

(2) Technical discussions and other activities regarding the application or adaptation of the person's products or services for an agency's use.

(D) The following agency and legislative liaison activities are permitted where they are prior to formal solicitation of any covered Federal action--

(1) Providing any information not specifically requested but necessary for an agency to make an informed decision about initiation of a covered Federal action;

(2) Technical discussions regarding the preparation of an unsolicited proposal prior to its official submission; and

(3) Capability presentations by persons seeking awards from an agency pursuant to the provisions of

the Small Business Act, as amended by Pub. L. 95-507, and subsequent amendments.

(E) Only those services expressly authorized by subdivision (b)(3)(i)(a) of this clause are permitted under this clause.

(ii) *Professional and technical services.*

(A) The prohibition on the use of appropriated funds, in subparagraph (b)(1) of this clause, does not apply in the case of--

(1) A payment of reasonable compensation made to an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action, if payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law, as a condition for receiving that Federal action.

(2) Any reasonable payment to a person, other than an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action if the payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action. Persons other than officers or employees of a person requesting or receiving a covered Federal action include consultants and trade associations.

(B) For purposes of subdivision (b)(3)(ii)(a) of this clause, "professional and technical services" shall be

limited to advice and analysis directly applying any professional or technical discipline. For example, drafting of a legal document accompanying a bid or proposal by a lawyer is allowable. Similarly, technical advice provided by an engineer on the performance or operational capability of a piece of equipment rendered directly in the negotiation of a contract is allowable. However, communications with the intent to influence made by a professional (such as a licensed lawyer) or a technical person (such as a licensed accountant) are not allowable under this section unless they provide advice and analysis directly applying their professional or technical expertise and unless the advice or analysis is rendered directly and solely in the preparation, submission or negotiation of a covered Federal action. Thus, for example, communications with the intent to influence made by a lawyer that do not provide legal advice or analysis directly and solely related to the legal aspects of his or her client's proposal, but generally advocate one proposal over another are not allowable under this section because the lawyer is not providing professional legal services. Similarly, communications with the intent to influence made by an engineer providing an engineering analysis prior to the preparation or submission of a bid or proposal are not allowable under this section since the engineer is providing technical services but not directly in the preparation, submission or negotiation of a covered Federal action.

(C) Requirements imposed by or pursuant to law as a condition for receiving a covered Federal award include those required by law or regulation and any other requirements in the actual award documents.

(D) Only those services expressly authorized by subdivisions (b)(3)(ii)(A)(1) and (2) of this clause are permitted under this clause.

(E) The reporting requirements of FAR 3.803(a) shall not apply with respect to payments of reasonable compensation made to regularly employed officers or employees of a person.

(c) *Disclosure.*

(1) The Contractor who requests or receives from an agency a Federal contract shall file with that agency a disclosure form, OMB standard form LLL, Disclosure of Lobbying Activities, if such person has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered Federal action), which would be prohibited under subparagraph (b)(1) of this clause, if paid for with appropriated funds.

(2) The Contractor shall file a disclosure form at the end of each calendar quarter in which there occurs any event that materially affects the accuracy of the information contained in any disclosure form previously filed by such person under subparagraph (c)(1) of this clause. An event that materially affects the accuracy of the information reported includes--

(i) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered Federal action; or

(ii) A change in the person(s) or individual(s) influencing or attempting to influence a covered Federal action; or

(iii) A change in the officer(s), employee(s), or Member(s) contacted to influence or attempt to influence a covered Federal action,

(3) The Contractor shall require the submittal of a certification, and if required, a disclosure form by any person who requests or receives any subcontract exceeding $100,000 under the Federal contract.

(4) All subcontractor disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the prime Contractor. The prime Contractor shall submit all disclosures to the Contracting Officer at the end of the calendar quarter in which the disclosure form is submitted by the subcontractor. Each subcontractor certification shall be retained in the subcontract file of the awarding Contractor.

(d) *Agreement.* The Contractor agrees not to make any payment prohibited by this clause.

(e) *Penalties.*

(1) Any person who makes an expenditure prohibited under paragraph (a) of this clause or who fails to file or amend the disclosure form to be filed or amended by paragraph (b) of this clause shall be subject to civil penalties as provided for by 31 U.S.C. 1352. An imposition of a civil penalty does not prevent the Government from seeking any other remedy that may be applicable.

(2) Contractors may rely without liability on the representation made by their subcontractors in the certification and disclosure form.

(3) *Cost allowability.* Nothing in this clause makes allowable or reasonable any costs which would otherwise be unallowable or unreasonable.

Conversely, costs made specifically unallowable by the requirements in this clause will not be made allowable under any other provision.

SECTION 5.46
[RESERVED]

SECTION 5.47
PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED OR PROPOSED FOR DEBARMENT (JAN 2005) (FAR 52.209-6)

(a) The Government suspends or debars Contractors to protect the Government's interests. The Contractor shall not enter into any subcontract in excess of $25,000 with a Contractor that is debarred, suspended, or proposed for debarment unless there is a compelling reason to do so.

(b) The Contractor shall require each proposed first-tier subcontractor, whose subcontract will exceed $25,000, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by the Federal Government.

(c) A corporate officer or a designee of the Contractor shall notify the Contracting Officer, in writing, before entering into a subcontract with a party that is debarred, suspended, or proposed for debarment (see FAR 9.404 for information on the Excluded Parties List System). The notice must include the following:

(1) The name of the subcontractor.

(2) The Contractor's knowledge of the reasons for the subcontractor being in the Excluded Parties List System.

(3) The compelling reason(s) for doing business with the subcontractor notwithstanding its inclusion in the Excluded Parties List System.

(4) The systems and procedures the Contractor has established to ensure that it is fully protecting the Government's interests when dealing with such subcontractor in view of the specific basis for the party's debarment, suspension, or proposed debarment.

SECTION 5.48
BANKRUPTCY (JUL 1995) (FAR 52.242-13)

In the event the Contractor enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the Contractor agrees to furnish, by certified mail or electronic, commerce method authorized by the contract, written notification of the bankruptcy to the Contracting Office responsible for administering the contract. This notification shall be furnished within five days of the initiation of the proceedings relating to bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, and a listing of Government contract numbers and contracting offices for all Government contracts against which final payment has not been made. This obligation remains in effect until final payment under this contract.

SECTION 5.49
FEHBP TERMINATION FOR CONVENIENCE OF THE GOVERNMENT—NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-71)

(a) The Government may terminate performance of work under this contract in whole or, from time to time, in part if the Contracting Officer determines that a termination is in the Government's interest. The Contracting Officer shall terminate by delivering to the Carrier a Notice of Termination specifying the extent of terminating and the effective date.

(b) After receipt of a Notice of Termination, and except as directed by the Contracting Officer, the Carrier shall immediately proceed with the following obligations, regardless of any delay in determining or adjusting any amounts due under this clause:

(1) Stop work as specified in the notice.

(2) Place no further subcontracts except as necessary to complete the continued portion of the contract.

(3) Terminate all subcontracts to the extent they relate to the work terminated.

(4) Assign to the Government, as directed by the Contracting Officer, all right, title, and interest of the Carrier under the subcontracts terminated, in which case the Government shall have the right to settle or to pay any termination settlement proposal arising out of those terminations.

(5) With approval or ratification to the extent required by the Contracting Officer, settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts;

the approval or ratification will be final for purposes of this clause.

(6) As directed by the Contracting Officer, deliver to the Government any data, reports, or studies that, if the contract had been completed, would be required to be furnished to the Government.

(7) Complete performance of the work not terminated.

(c) After termination, the Carrier shall submit a final termination settlement proposal to the Contracting Officer in the form and with the certification proscribed by the Contracting Officer. The Carrier shall submit the proposal promptly, but no later than 1 year from the effective date of termination, unless extended in writing by the Contracting Officer upon written request of the Carrier within this 1-year period. However, if the Contracting Officer determines that the facts justify it, a termination settlement proposal may be received and acted on after 1 year or any extension. If the Carrier fails to submit the proposal within the time allowed, the Contracting Officer may determine, on the basis of information available, the amount, if any, due the Carrier because of the termination and shall pay the amount determined.

(d) Subject to paragraph (c) of this clause, the Carrier and the Contracting Officer may agree upon the whole or any part of the amount to be paid or remaining to be paid because of the termination. The amount may include a reasonable allowance for profit on work done. However, the agreed amount, whether under this paragraph (d) or paragraph (e) of this clause, exclusive of costs shown in subparagraph (e)(3) of this clause, may not exceed the total contract

price as reduced by (1) the amount of payments previously made and (2) the contract price of work not terminated. The contract shall be modified, and the Carrier paid the agreed amount. Paragraph (e) of this clause shall not limit, restrict, or affect the amount that may be agreed upon to be paid under this paragraph.

(e) If the Carrier and the Contracting Officer fail to agree on the whole amount to be paid because of the termination of work, the Contracting Officer shall pay the Carrier the amounts determined by the Contracting Officer as follows, but without duplication of any amounts agreed on under paragraph (d) above:

(1) The contract price for completed services accepted by the Government not previously paid for.

(2) The total of –

(i) The costs incurred in the performance of the work terminated, including initial costs and preparatory expense allocable thereto, but excluding any costs attributable to services paid or to be paid under paragraph (e)(1) of this clause;

(ii) The cost of settling and paying termination settlement proposals under terminated subcontracts that are properly chargeable to the terminated portion of the contract if not included in subdivision (e)(2)(i) of this clause; and

(iii) A sum, as profit on subdivision (e)(2)(i) of this clause, determined by the Contracting Officer under 49.202 of the Federal Acquisition Regulation, in effect on the date of this contract, to be fair and reasonable.

(3) The reasonable costs of settlement of the work terminated, including--

(i) Accounting, legal, clerical, and other expenses reasonably necessary for the preparation of termination settlement proposals and supporting data;

(ii) The termination and settlement of subcontracts (excluding the amounts of such settlements); and

(f) The cost principles and procedures of part 31 of the Federal Acquisition Regulation, in effect on the date of this contract, shall govern all costs claimed, agreed to, or determined under this clause.

(g) The Carrier shall have the right of appeal, under the Disputes clause, from any determination made by the Contracting Officer under paragraph (c), (e), or (i) of this clause, except that if the Carder failed to submit the termination settlement proposal or request for equitable adjustment within the time provided in paragraph (c) or (i), respectively, and failed to request a time extension, there is no right of appeal.

(h) In arriving at the amount due the Carrier under this clause, there shall be deducted--

(1) All unliquidated advance or other payments to the Carrier under the terminated portion of this contract;

(2) Any claim which the Government has against the Carrier under this contract; and

(i) If the termination is partial, the Carrier may file a proposal with the Contracting Officer for an equitable adjustment of the price(s) of the continued portion of the contract. The Contracting Officer shall make any equitable adjustment agreed upon. Any

proposal by the Carrier for an equitable adjustment under this clause shall be requested within 90 days from the effective date of termination unless extended in writing by the Contracting Officer.

(j)(1) The Government may, under the terms and conditions it prescribes, make partial payments and payments against costs incurred by the Carrier for the terminated portion of the contract, if the Contracting Officer believes the total of these payments will not exceed the amount to which the Carrier will be entitled.

(2) If the total payments exceed the amount finally determined to be due, the Carrier shall repay the excess to the Government upon demand, together with interest computed at the rate established by the Secretary of the Treasury under 50 U.S.C. App. 1215(b)(2), Interest shall be computed for the period from the date the excess payment is received by the Carrier to the date the excess is repaid.

(k) Unless otherwise provided in this contract or by statute, the Carrier shall maintain all records and documents relating to the terminated portion of this contract for 3 years after final settlement. This includes all books and other evidence bearing on the Carrier's costs and expenses under this contract. The Carrier shall make these records and documents available to the Government, at the Carrier's office, at all reasonable times, without any direct charge. If approved by the Contracting Officer, photographs, microphotographs, or other authentic reproductions may be maintained instead of original records and documents.

SECTION 5.50
FEHBP TERMINATION FOR DEFAULT--NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-72)

(a)(1) The Government may, subject to paragraphs (c) and (d) below, by written notice of default to the Carrier, terminate this contract in whole or in part if the Carrier fails to –

(i) Perform the services within the time specified in this contract or any extension;

(ii) Make progress, so as to endanger performance of this contract (but see subparagraph (a)(2) below); or

(iii) Perform any of the other provisions of this contract (but see subparagraph (a)(2) below).

(2) The Government's right to terminate this contract under subdivisions (1)(ii) and (1)(iii) above, maybe exercised if the Carrier does not cure such failure within 10 days (or more if authorized in writing by the Contracting Officer) after receipt of the notice from the Contracting Officer specifying the failure.

(b) If the Government terminates this contract in whole or in part, it may acquire, under the terms and in the manner the Contracting Officer considers appropriate, supplies or service similar to those terminated, and the Carrier will be liable to the Government for any excess costs for those supplies or services. However, the Carrier shall continue the work not terminated.

(c) Except for defaults of subcontractors at any tier, the Carrier shall not be liable for any excess costs if the failure to perform the contract arises

from causes beyond the control and without the fault or negligence of the Carrier. Examples of such causes include (1) acts of God or of the public enemy, (2) acts of the Government in either its sovereign or contractual capacity, (3) fires, (4) floods, (5) epidemics, (6) quarantine restrictions, (7) strikes, (8) freight embargoes, and (9) unusually severe weather. In each instance the failure to perform must be beyond the control and without the fault or negligence of the Carrier.

(d) If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both the Carrier and subcontractor, and without the fault or negligence of either, the Carrier shall not be liable for any excess costs for failure to perform, unless the subcontracted supplies or services were obtainable from other sources in sufficient time for the Carrier to meet the required delivery schedule.

(e) If this contract is terminated for default, the Government may require the Carrier to transfer title and deliver to the Government, as directed by the Contracting Officer, any completed or partially completed information and contract rights that the Carrier has specifically produced or acquired for the terminated portion of this contract.

(f) If, after termination, it is determined that the Carrier was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the Government.

(g) The rights and remedies of the Government in this clause are in addition to any other rights and remedies provided by law or under this contract.

SECTION 5.51 thru 5.52
[RESERVED]

SECTION 5.53
NOTICE TO THE GOVERNMENT OF LABOR DISPUTES (FEB 1997) (FAR 52.222-1)

If the Contractor has knowledge that any actual or potential labor dispute is delaying or threatens to delay the timely performance of this contract, the Contractor shall immediately give notice, including all relevant information, to the Contracting Officer.

SECTION 5.54
[RESERVED]

SECTION 5.55
EMPLOYMENT REPORTS ON SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (DEC 2001) (FAR 52.222-37)

(a) Unless the Contractor is a State or local government agency, the Contractor shall report at least annually, as required by the Secretary of Labor, on--

(1) The number of special disabled veterans, the number of veterans of the Vietnam era, and other eligible veterans in the workforce of the contractor by job category and hiring location; and

(2) The total number of new employees hired during the period covered by the report, and of the total, the number of special disabled veterans, the number of veterans of the Vietnam era, and the number of other eligible veterans; and

(3) The maximum number and the minimum number of employees of the Contractor during the period covered by the report.

(b) The Contractor shall report the above items by completing the Form VETS-100, entitled "Federal Contractor Veterans' Employment Report (VETS-100 Report)."

(c) The Contractor shall submit VETS-100 Reports no later than September 30 of each year beginning September 30, 1988.

(d) The employment activity report required by paragraph (a)(2) of this clause shall reflect total hires during the most recent 12-month period as of the ending date selected for the employment profile report required by paragraph (a)(1) of this clause. Contractors may select an ending date--

(1) As of the end of any pay period between July 1 and August 31 of the year the report is due; or

(2) As of December 31, if the Contractor has prior written approval from the Equal Employment Opportunity Commission to do so for purposes of submitting the Employer Information Report EEO-1 (Standard Form 100).

(e) The Contractor shall base the count of veterans reported according to paragraph (a) of this clause on voluntary disclosure. Each Contractor subject to the reporting requirements at 38 U.S.C. 4212 shall invite all special disabled veterans, veterans of the Vietnam era, and other eligible veterans who wish to benefit under the affirmative action program at 38 U.S.C. 4212 to identify themselves to the Contractor. The invitation shall state that—

(1) The information is voluntarily provided;

(2) The information will be kept confidential;

(3) Disclosure or refusal to provide the information will not subject the applicant or employee to any adverse treatment; and

(4) The information will be used only in accordance with the regulations promulgated under 38 U.S.C. 4212.

(f) The Contractor shall insert the terms of this clause in all subcontracts or purchase orders of $25,000 or more unless exempted by rules, regulations, or orders of the Secretary of Labor.

SECTION 5.56
AUTHORIZATION AND CONSENT (JUL 1995)
(FAR 52.227-1)

(a) The Government authorizes and consents to all use and manufacture, in performing this contract or any subcontract at any tier, of any invention described in and covered by a United States patent (1) embodied in the structure or composition of any article the delivery of which is accepted by the Government under this contract or (2) used in machinery, tools, or methods whose use necessarily results from compliance by the Contractor or a subcontractor with (i) specifications or written provisions forming a part of this contract or (ii) specific written instructions given by the Contracting Officer directing the manner of performance. The entire liability to the Government for infringement of a patent of the United States shall be determined solely by the provisions of the indemnity clause, if any, included in this contract or any subcontract hereunder (including any lower-tier subcontract), and the Government assumes liability for all other infringement to the extent of the authorization and consent hereinabove granted.

(b) The Contractor agrees to include, and require inclusion of, this clause, suitably modified to identify the parties, in all subcontracts at any tier for supplies or services (including construction, architect-engineer services, and materials, supplies, models, samples, and design or testing services expected to exceed the simplified acquisition threshold); however, omission of this clause from any subcontract, including those at or below the simplified acquisition threshold, does not affect this authorization and consent.

SECTION 5.57
NOTICE AND ASSISTANCE REGARDING
PATENT AND COPYRIGHT INFRINGEMENT
(AUG 1996) (FAR, 52.227-2)

(a) The Contractor shall report to the Contracting Officer, promptly and in reasonable written detail, each notice or claim of patent or copyright infringement based on the performance of this contract of which the contractor has knowledge.

(b) In the event of any claim or suit against the Government on account of any alleged patent or copyright infringement arising out of the performance of this contract or out of the use of any supplies furnished or work or services performed under this contract, the Contractor shall furnish to the Government, when requested by the Contracting Officer, all evidence and information in possession of the Contractor pertaining to such suit or claim. Such evidence and information shall be furnished at the expense of the Government except where the Contractor has agreed to indemnify the Government.

(c) The Contractor agrees to include, and require inclusion of, this clause, in all subcontracts at any

tier for supplies or services (including construction and architect-engineer subcontracts and those for materials, supplies, models, samples, or design or testing services) expected to exceed the simplified acquisition threshold at FAR 2.101.

SECTION 5.58
PAYMENT BY ELECTRONIC FUNDS TRANSFER—CENTRAL CONTRACTOR REGISTRATION (OCT 2003) (FAR 52.232-33)

(a) *Method of payment.* (1) All payments by the Government under this contract shall be made by electronic funds transfer (EFT), except as provided in paragraph (a)(2) of this clause. As used in this Clause, the term "EFT" refers to the funds transfer and may also include the payment information transfer.

(2) In the event the Government is unable to release one or more payments by EFT, the Contractor agrees to either--

(i) Accept payment by check or some other mutually agreeable method of payment; or (ii) Request the Government to extend the payment due date until such time as the Government can make payment by EFT (but see paragraph (d) of this clause).

(b) *Contractor's EFT information.* The Government shall make payment to the Contractor using the EFT information contained in the Central Contractor Registration (CCR) database. In the event that the EFT information changes, the Contractor shall be responsible for providing the updated information to the CCR database.

(c) *Mechanisms for EFT payment.* The Government may make payment by EFT through either the Automated Clearing House (ACH) network, subject

to the rules of the National Automated Clearing House Association, or the Fed Wire Transfer System. The rules governing Federal payments through the ACH are contained in 31 CFR part 210.

(d) *Suspension of payment.* If the Contractor's EFT information in the CCR database is incorrect, then the Government need not make payment to the Contractor under this contract until correct EFT information is entered into the CCR database; and any invoice or contract financing request shall be deemed not to be a proper invoice for the purpose of prompt payment under this contract. The prompt payment terms of the contract regarding notice of an improper invoice and delays in accrual of interest penalties apply.

(e) *Liability for uncompleted or erroneous transfers.* (1) If an uncompleted or erroneous transfer occurs because the Government used the Contractor's EFT information incorrectly, the Government remains responsible for — (i) Making a correct payment;

(ii) Paying any prompt payment penalty due; and

(iii) Recovering any erroneously directed funds.

(2) If an uncompleted or erroneous transfer occurs because the Contractor's EFT information was incorrect, or was revised within 30 days of Government release of the EFT payment transaction instruction to the Federal Reserve System, and —

(i) If the funds are no longer under the control of the payment office, the Government is deemed to have made payment and the Contractor is responsible for recovery of any erroneously directed funds; or

(ii) If the funds remain under the control of the payment office, the Government shall not make payment, and the provisions of paragraph (d) of this clause shall apply.

(f) *EFT and prompt payment.* A payment shall be deemed to have been made in a timely manner in accordance with the prompt payment terms of this contract if, in the EFT payment transaction instruction released to the Federal Reserve System, the date specified for settlement of the payment is on or before the prompt payment due date, provided the specified payment date is a valid date under the rules of the Federal Reserve System.

(g) *EFT and assignment of claims.* If the Contractor assigns the proceeds of this contract as provided for in the assignment of claims terms of this contract, the Contractor shall require as a condition of any such assignment, that the assignee shall register separately in the CCR database and shall be paid by EFT in accordance with the terms of this clause. Notwithstanding any other requirement of this contract, payment to an ultimate recipient other than the Contractor, or a financial institution properly recognized under an assignment of claims pursuant to subpart 32.8 is not permitted. In all respects, the requirements of this clause shall apply to the assignee as if it were the Contractor. EFT information that shows the ultimate recipient of the transfer to be other than the Contractor, in the absence of a proper assignment of claims acceptable to the Government, is incorrect EFT information within the meaning of paragraph (d) of this clause.

(h) *Liability for change of EFT information by financial agent.* The Government is not liable for er-

rors resulting from changes to EFT information made by the Contractor's financial agent.

(i) *Payment information.* The payment or disbursing office shall forward to the Contractor available payment information that is suitable for transmission as of the date of release of the EFT instruction to the Federal Reserve System. The Government may request the Contractor to designate a desired format and method(s) for delivery of payment information from a list of formats and methods the payment office is capable of executing. However, the Government does not guarantee that any particular format or method of delivery is available at any particular payment office and retains the latitude to use the format and delivery method most convenient to the Government, If the Government makes payment by check in accordance with paragraph (a) of this clause, the Government shall mail the payment information to the remittance address contained in the CCR database.

(End of clause)

SECTION 5.59
PROHIBITION OF SEGREGATED FACILITIES
(FEB 1999) (FAR 52.222,21)

(a) "Segregated facilities," as used in this clause, means any waiting rooms, work areas, test rooms and wash rooms, restaurants and other eating areas, time clocks, locker rooms and other storage or dressing areas, parking lots, drinking fountains, recreation or entertainment areas, transportation, and housing facilities provided for employees, that are segregated by explicit directive or are in fact segregated on the basis of race, color, religion, sex, or national origin because of written or oral policies or

employee custom. The term does not include separate or single-user rest rooms or necessary dressing or sleeping areas provided to assure privacy between the sexes.

(b) The Contractor agrees that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not and will not permit its employees to perform their services at any location under its control where segregated facilities are maintained. The Contractor agrees that a breach of this clause is a violation of the Equal Opportunity clause in this contract.

(c) The Contractor shall include this clause in every subcontract and purchase order that is subject to the Equal Opportunity clause of this contract.

SECTION 5.60
[RESERVED]

SECTION 5.61
NOTIFICATION OF EMPLOYEE RIGHTS CONCERNING PAYMENT OF UNION DUES OR FEES (DEC 2004) (FAR 52.222-39)

(a) Definition. As used in this clause—

"United States" means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(b) Except as provided in paragraph (e) of this clause, during the term of this contract, the Contractor shall post a notice, in the form of a poster, informing employees of their rights concerning union membership and payment of union dues and fees, in conspicuous places in and about all its plants and of-

fices, including all places where notices to employees are customarily posted. The notice shall include the following information (except that the information pertaining to National Labor Relations Board shall not be included in notices posted in the plants or offices of carriers subject to the Railway Labor Act, as amended (45 U.S.C. 151-188)).

Notice to Employees

Under Federal law, employees cannot be required to join a union or maintain membership in a union in order to retain their jobs. Under certain conditions, the law permits a union and an employer to enter into a union security agreement requiring employees to pay uniform periodic dues and initiation fees. However, employees who are not union members can object to the use of their payments for certain purposes and can only be required to pay their share of union costs relating to collective bargaining, contract administration, and grievance adjustment.

If you do not want to pay that portion of dues or fees used to support activities not related to collective bargaining, contract administration, or grievance adjustment, you are entitled to an appropriate reduction in your payment. If you believe that you have been required to pay dues or fees used in part to support activities not related to collective bargaining, contract administration, or grievance adjustment, you may be entitled to a refund and to an appropriate reduction in future payments.

For further information concerning your rights, you may wish to contact the National Labor Relations Board (NLRB) either at one of its Regional offices or at the following address or toll free number:

National Labor Relations Board
Division of Information
1099 14th Street, N.W.
Washington, DC 20570
1-866-667-6572
1-866316-6572 (TTY)

To locate the nearest NLRB office, see NLRB's website at http://www.nlrb.gov.

(c) The Contractor shall comply with all provisions of Executive Order 13201 of February 17, 2001, and related implementing regulations at 29 CFR Part 470, and orders of the Secretary of Labor.

(d) In the event that the Contractor does not comply with any of the requirements set forth in paragraphs (b), (c), or (g), the Secretary may direct that this contract be cancelled, terminated, or suspended in whole or in part, and declare the Contractor ineligible for further Government contracts in accordance with procedures at 29 CFR Part 470, Subpart B—Compliance Evaluations, Complaint Investigations and Enforcement Procedures. Such other sanctions or remedies may be imposed as are provided by 29 CFR Part 470, which implements Executive Order 13201, or as are otherwise provided by law.

(e) The requirement to post the employee notice in paragraph (b) does not apply to—

(1) Contractors and subcontractors that employ fewer than 15 persons;

(2) Contractor establishments or construction work sites where no union has been formally recognized by the Contractor or certified as the exclusive bargaining representative of the Contractor's employees;

(3) Contractor establishments or construction work sites located in a jurisdiction named in the definition of the United States in which the law of that jurisdiction forbids enforcement of union-security agreements;

(4) Contractor facilities where upon the written request of the Contractor, the Department of Labor Deputy Assistant Secretary for Labor-Management Programs has waived the posting requirements with respect to any of the Contractor's facilities if the Deputy Assistant Secretary finds that the Contractor has demonstrated that—

(i) The facility is in all respects separate and distinct from activities of the Contractor related to the performance of a contract; and

(ii) Such a waiver will not interfere with or impede the effectuation of the Executive order; or

(5) Work outside the United States that does not involve the recruitment or employment of workers within the United States.

(f) The Department of Labor publishes the official employee notice in two variations; one for contractors covered by the Railway Labor Act and a second for all other contractors. The Contractor shall—

(1) Obtain the required employee notice poster from the Division of Interpretations and Standards, Office of Labor-Management Standards, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-5605, Washington, DC 20210, or from any field office of the Department's Office of Labor-Management Standards or Office of Federal Contract Compliance Programs;

(2) Download a copy of the poster from the Office of Labor-Management Standards website at http://www.olms.dol.gov; or

(3) Reproduce and use exact duplicate copies of the Department of Labor's official poster.

(g) The Contractor shall include the substance of this clause in every subcontract or purchase order that exceeds the simplified acquisition threshold, entered into in, connection with this contract, unless exempted by the Department of Labor Deputy Assistant Secretary for Labor-Management Programs on account of special circumstances in the national interest under authority of 29 CFR. 470.3(c). For indefinite quantity subcontracts, the Contractor shall include the substance of this clause if the value of orders in any calendar year of the subcontract is expected to exceed the simplified acquisition threshold. Pursuant to 29 CFR Part 470, Subpart B–Compliance Evaluations, Complaint Investigations and Enforcement Procedures, the Secretary of Labor may direct the Contractor to take such action in the enforcement of these regulations, including the imposition of sanctions for noncompliance with respect to any such subcontract or purchase order. If the Contractor becomes involved in litigation with a subcontractor or vendor, or is threatened with such involvement, as a result of such direction, the Contractor may request the United States, through the Secretary of Labor, to enter into such litigation to protect the interests of the United States.

SECTION 5.62
APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004) (FAR 52.233-4)

United States law will apply to resolve any claim of breach of this contract.

APPENDIX A

ATTACH

2006 FEHB BROCHURE

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Community-Rated

Health Maintenance Organization Carrier

GROUP HEALTH PLAN, INC.

CONTRACT NO. CS 1930

Effective January 1, 2006

Biweekly net-to-carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

High Option Self Only	$221.65
High Option Self and Family	$478.75
High Deductible Health Plan Self Only	$176.96
High Deductible Health Plan Self and Family	$379.43

APPENDIX C
FEHB Supplemental Literature Guidelines
(RV JAN 2000)

This is the primary guide a Carrier should use to assess whether the Carrier's supplemental marketing literature, including website material, complies with FEHBAR 1603.70, Misleading, Deceptive or Unfair Advertising. (Use the NAIC Advertisements of Accident and Sickness insurance Model Regulation for additional guidance when needed.)

a) GENERAL

1. Section 1.13 of the FMB contract requires that the Carrier may not distribute or display marketing materials or other supplemental literature (including provider directories) in a Federal facility or arrange for the distribution of such documents by Federal agencies unless the documents have been prepared in accordance with FEHBAR 1652.203-70, and the Carrier has certified to OPM that is the case.

2. Review supplemental marketing material for compliance each year, whether or not it changed from the past year.

3. Word the literature simply and concisely to get a readily understandable, attractive marketing piece.

4. Include sufficient detail to ensure accuracy.

5. Under the FUMY, the FBHB brochure is based on text approved by OPM and is a complete statement of benefits, limitations, and exclusions. Include the following statement (website material should include the statement as a preface) in all supplemental literature which in any way discusses Plan benefits:

"This is a summary for brief description] of the features of the [insert Plan's name]. Before making a final decision, please read the Plan's Federal brochure ((insert brochure number]). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure."

6. You may include non-FEHB benefits, i.e., benefits which are not FEHB benefits and are not guaranteed under the Federal contract with the following disclaimer:

"These benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all enrollees and family members who become members of [insert Plan's name]."

7. Supplemental literature must be clearly distinguishable from the Federal brochure.

8. Do not use the FEHB logo in your supplemental literature.

9. Do not use material which conflicts with the Federal brochure. If your material conflicts, you must change the material or not distribute it.

b) RATE PRESENTATIONS

Under the FEHBP there are only two categories of enrollment, Self Only and Self and Family. For most enrollments, the premium for each enrollee's enrollment is shared between the enrollee-and the Government, The Government contribution is based on the formula provided in the FEHB law. Deductions for most enrollees' share, along with the Government's contribution, are made in accordance with the schedule on which the employee or annuitant's (retiree) salary or annuitant check is issued by the enrollee's agency or retiree's retirement system.

Most employees are paid biweekly. Annuitants are issued monthly checks.

Employees and annuitants do not have separate categories of enrollment. They pay the same rates, whether on a biweekly, semimonthly, or monthly basis, and receive the same benefits when they are in the same FEHB Plan, except that active Postal employees pay a lesser share, as their cost sharing formula with the Postal Service calls for a greater Government contribution.

The enrollee's share for each FEND Plan for each type of enrollment (Self Only, Self and 'Family) is listed in the FEHB Guide. This Guide is prepared each Open Season and is distributed directly to agencies by OPM; they in turn distribute the Guide to employees, Biweekly and monthly rates are also shown on an insert you prepare for your brochure, Separate guides are prepared for special groups of enrollees, including those for which the Government makes no premium contribution, such as former spouses and employees and dependents with temporarily continued coverage.

In making your rate presentations:

1. List your FEHB rates in each piece of supplemental material which lists benefits. Do not list the rates of any competitor Plan.

2. Immediately above the rates include the following statement:

"These rates .do not apply to all enrollees. If you are in a special enrollment category, please refer to your special FEHB Guide or contact the agency which maintains your health benefits enrollment."

3. If you wish to list Postal rates in addition to non-Postal rates, Postal and non-Postal rates should be clearly identified and listed separately. (Please note there are no monthly Postal rates; upon retirement, Postal employees receive the non-postal contribution.)

c) BENEFIT PRESENTATIONS

Please note the following:

1. Do not compare your benefits or operations with that of any other Plan.

2. Accurately describe your FEHB benefits offering.

3. Avoid incomplete or overstated benefit descriptions, or those which conflict with the Federal brochure.

4. Show applicable coverage limitations, such as day or dollar limitations, coinsurance or deductibles.

5. Do not list exclusions and limitations not listed in the Federal brochure.

6. Do not include general references not in the brochure.

7. Do not reference coverage for which a Federal employee or retiree would have to drop FEUD coverage. Exception: 5 CFR 890.301 provides that an annuitant or former spouse, as defined in 5 U.S.C. S901(10), who cancels FEHBP enrollment for the purpose of enrolling in a Health Maintenance Organization health Plan under sections 1833 or 1876 of the Social Security Act may register to re-enroll. Therefore, if yours is such a Health Maintenance Organization health Plan contracting with Medicare

you must describe your Medicare supplemental program for Medicare-covered retirees.

d) ENROLLMENT INSTRUCTIONS

Enrollment under the FEHBP is governed solely by the Federal Employees Health Benefits law and applicable regulations. The various Federal agencies have responsibility for administering the law and regulations during the annual open enrollment period (Open Season) and at all other times during the year. Agency personnel offices perform the basic health benefits functions, such as instructing employees about the conduct of the Open Season and other health benefits matters, answering employee questions, and processing elections and changes of enrollment, including determinations of eligibility end assignment of effective dates of coverage. Agency payroll offices make the necessary salary deductions.

The Federal instrument for electing to enroll in a Plan or changing an existing enrollment in a Plan from Self Only to Self and Family (or the reverse) is the Standard Form (SF) 2809, or alternative electronic or telephonic method approved by OPM. Carriers must be able to accept electronic -file transfers. The effective date for Open Season enrollments is the first day of the first pay period which begins on or after January 1 for employees; the effective date generally is January 1 for annuitants. The specific effective date for an individual will be assigned by the individual's personnel office.

Covered dependents are as defined in the FEHB regulations. Basically, dependents are immediate family members, including spouse and unmarried children under age 22, When Self and Family cover-

age is established for an individual, all dependents as defined under the regulations are automatically covered as of the effective date assigned by the personnel office, whether or not they are listed on the SF 2809, on other documents, or communicated by electronic or telephonic transmittal. Family members (e.g., newborns) who are added under an existing Self and Family enrollment are automatically covered from the date the individual becomes a family member, e.g., from birth. Personnel offices do not issue any notification when a new dependent is added under an existing Self and Family enrollment and the enrollee does not submit a new SF 2809 or other election instrument,

The agencies are the primary contact point for employees on health benefits enrollment matters. OPM's Office of Retirement Programs performs this function for annuitants (retirees). As highlighted below, Carriers may not impose their own enrollment requirements and procedures.

1. Do not give specific instructions on enrollment.

2. While the Carrier may ask enrollees for information (see Section f) and may follow-up with enrollees and, when necessary, the employing office, do not require that a member complete plan specific enrollment or application forms. You may ask the enrollee to complete "information" forms.) You may ask the enrollee to keep you advised of family member changes and you may verify the change, but failure to complete a form does not render an eligible dependent ineligible.

3. Personnel offices will not stock your Plan's forms. Do not indicate otherwise.

4. If supplemental literature is directed to potential members rather than just-enrolled members, do not include statements indicating otherwise.

5. Again, the Federal brochure, rather than any other plan document, is the member's complete statement of benefits. Do not indicate otherwise.

e) PROVIDER DIRECTORIES

Carriers must distribute a provider directory along with the Plan's Federal brochure. The directory must conform to the requirements listed below. You must either send a copy of it along with your Federal brochures (except that provider directories are not to be sent along with the brochures you will be sending to OPM's distribution center for annuitants) or otherwise make them readily available to agencies and employees. Please send a provider directory to any Federal annuitant who requests a copy. Agencies and their employees will be advised to expect your provider directory.

Please bear in mind that a Federal employee or annuitant choosing your Plan during the Open Season is doing so with the expectation that the Plan's provider directory is accurate and that providers shown will be available starting January 1.

1. Show the Plan's medical facilities (if a group practice Plan) or individual physicians (if an individual practice Plan) or both (if a mixed model Plan). Show the Plan's hospitals also State-the addresses of the medical facilities and show the general location within the service area for individual doctors and hospitals.

2. In the directory, display prominently the following statement: "It is important to know when you enroll in this Plan, services are provided through The

Plan's -delivery system, as described in the Plan's Federal brochure, but the continued participation of any one doctor, hospital or other provider cannot be guaranteed."

3. Do not list enrollment or eligibility requirements on the provider directory,

4. If the geographic area from which the Carrier will accept enrollments is listed on the provider directory, show it exactly as stated in the Plan's Federal brochure. Likewise, show only the service area which has been approved by OPM. Do not list providers (or areas) located outside the service area (or additional geographic area) shown in the Plan's Federal brochure.

f) INFORMATION FORMS

You may distribute forms to obtain information from enrollees about the enrollee and any dependents, For instance, to obtain the information regarding Medicare you will need for rate-setting purposes under the Federal Program, you may ask who is enrolled under Medicare Part A, Medicare Part B or Medicare Parts A and B. For another example, Health Maintenance Organization carriers may ask that a primary care doctor be selected. If you wish to distribute an information form, you may find such forms are more readily returned if they are postage-paid. The form should follow the requirements listed below:

(l) If the member must select a medical group or IPA, also provide space for the member to make such a selection.

(2) Do not indicate enrollment in the Plan is contingent upon completing and returning the form.

APPENDIX D

RULES FOR COORDINATION OF BENEFITS

Model Regulation Service--January 1996
National Association of insurance Commissioners

When a person is covered by two (2) or more plans, the roles for determining the order of benefit payments are as follows:

A. The primary plan must pay or provide its benefits as if the secondary, plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A. plan may consider the benefits paid or provided by another plan only when ii is secondary to that other plan.

D. Order of Benefit Determination. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

(1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retir-

ee, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) Secondary to the plan covering the person as a dependent; and

(b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) Child Covered Under More Than One Plan.

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

(i) The parents are married;

(ii) The parents are not separated (whether or not they ever have been married); or

(iii) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's

spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(d) If the parents are not married or are separated (whether or not they over were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(i) The plan of the custodial parent;

(ii) The plan of the spouse of the custodial parent;

(iii) The plan of the noncustodial patent; and then

(iv) The plan of the spouse of the noncustodial parent.

(3) Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off not retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection D(1).

Drafting Note: This rule covers the situation where one individual is covered under one policy as an active worker and under another policy as a retired worker. It would also apply to an individual covered as a dependent under both of those policies.

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Drafting Note: The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (COBRA 89) allows the COBRA coverage to continue if the new group plan contains any preexisting condition limitation. In this instance two group plans will cover an individual, and the rule above will be used to determine which of them assumes the primary position. In addition, some states have continuation provisions comparable to the federal law.

(5) Longer or Shorter Length of Coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours slier the first ended.

(b) The start of a new plan does not include:

(1) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of, the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

FIRST AMENDED CLASS ACTION PETITION FOR DAMAGES
(Mo. Cir. Ct. Oct. 31, 2011)

Plaintiff, Jodie Nevils, on behalf of himself and all others similarly situated, alleges and avers the following for this class action against Defendants:

INTRODUCTION AND BACKGROUND

1. This action is brought by the Plaintiff on behalf of himself and others similarly situated regarding the Defendants practice of asserting liens and/or rights of reimbursement against the personal injury settlements of Plaintiff and the Class Members when the Defendants had no legal right to assert said liens.

2. Upon information and belief, Defendant ACS Recovery Services, Inc. ("Defendant ACS") is a private corporate entity that contracts with health insurance companies to assert liens and rights of recovery on their behalf.

3. Defendant Group Health Plan, Inc. ("Defendant Group Health Plan") is a private corporate entity that contracts to provide health insurance to individual persons.

4. Upon information and belief, Group Health Plan contracts with the Federal government, through the Office of Personnel Management as a "carrier" to administer healthcare benefits in accordance with the provisions of the Federal Employee Health Benefits Act (FEHBA). 5 U.S.C. § 8901 *et. seq*.

5. FEHBA is a comprehensive statutory and regulatory scheme that provides federal employees, federal retirees, and their eligible family members with subsidized healthcare benefits.

6. The Defendants routinely engage in a widespread pattern and practice of unlawfully asserting reimbursement rights on healthcare benefits that are paid pursuant to health plans subject to the provisions of FEHBA.

7. For instance, occasionally an individual is injured in an auto accident and that individual's health care benefits are covered through a FEHBA plan. If that individual pursues legal action against the tortfeasor for his/her injuries, the Defendants unlawfully assert a lien for repayment of the health care benefits paid for such treatment.

8. Absent a Federal provision that affords lien/subrogation rights to Defendants, such rights, if they exist, are wholly derivative of state law.

9. There is no Federal provision that provides lien and/or subrogation rights to reimbursement for benefits paid by a FEHBA "carrier" such as Defendant Group Health Plan nor is there any authority for the Defendants to assert liens and/or rights of reimbursement.

10. Under Missouri law, subrogation on personal injury claims prohibited. Accordingly, since Missouri law controls whatever reimbursement rights to which the Defendants would be entitled, Defendants have no right of reimbursement for benefits paid pursuant to a FEBHA health plan.

11. Despite the fact that any reimbursement/subrogation rights are controlled by Missouri state law that prohibits such subrogation, Defendants routinely assert liens on personal injury recoveries of Missouri citizens and subrogate for repayment of health benefits paid out on personal injury claims of Missouri citizens.

12. Defendants pursue such course of conduct despite being informed repeatedly that they are not entitled to reimbursement of such funds under Missouri law.

13. By employing such a policy and business model, Defendants have unlawfully violated the rights of Plaintiff and the Class members as described more particularly below.

14. Further, such conduct of the Defendants, and their agents, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the rights of Plaintiff and the Class members such that punitive damages are appropriate and warranted.

JURISDICTION AND VENUE

15. This Court has personal jurisdiction over Defendant Group Health Plain and Defendant ACS since the Defendants transacted business in Missouri, violated the law within the State of Missouri, and otherwise has sufficient minimum contacts with the state of Missouri as more particularly described below. Defendants have sufficient minimum contacts, and in fact, substantial contacts with Missouri such that the maintenance of this suit does not offend traditional notions of fair play and substantial justice. Defendants have voluntarily submitted itself to the jurisdiction of this Court and jurisdiction is proper because, among other things:

a. Defendants committed tortious acts within this state;

b. Plaintiffs' and the Class members' causes of action directly arise from the commission of tortious and unlawful acts in Missouri by Defendants;

c. Plaintiffs' and the Class members' causes of action directly arise from Defendants' transaction(s) of business in Missouri;

d. Defendants should reasonably anticipate being haled into court in Missouri to answer for its unlawful acts. Missouri has a strong interest in providing a forum for its residents aggrieved by violations of the law.

16. Venue is proper in this Circuit pursuant to RSMo § 508.010 in that a substantial part of the events giving rise to the claim occurred in within this Circuit.

PARTIES

Plaintiff

17. Plaintiff Jodie Nevils currently resides in Saint Louis County, Missouri.

Defendants

18. Defendant Group Health Plan is a private health insurance provider. Group Health Plan is organized under the laws of Missouri and is authorized to do business in the Sate of Missouri.

19. Defendant ACS Recovery Services, Inc. is a Delaware Corporation.

ALLEGATIONS COMMON TO ALL COUNTS

20. On or about November 2, 2006, representative Plaintiff Jodie Nevils was injured in a motor vehicle accident.

21. Plaintiff Nevils received treatment for his injuries sustained in the accident from numerous healthcare providers.

22. Plaintiff Nevils asserted a personal injury claim against the driver tortfeasor for his injuries sustained in the November 2, 2006 accident.

23. Plaintiff Nevils reached a settlement with the tortfeasor, paid through the tortfeasor's auto insurance policy, in compensation for his injuries, medical treatment, and pain and suffering, sustained in the accident.

24. Plaintiff Nevils was entitled to medical insurance coverage through a federal health benefit plan. The health plan that covers Plaintiff is governed by the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914 ("FEHBA").

25. The federal government has contracted with Defendant Group Health Plan to act as a "carrier" under FEHBA to provide health benefits and administer the subsidized healthcare plan provided under FEHBA to enrollees such as Ms. Nevils.

26. Plaintiff Nevils' medical bills related to the auto accident were paid by Defendant Group Health Plan.

27. Defendant Group Health Plan and Defendant ACS unlawfully asserted a lien in the amount of $6,592.24 for healthcare benefits and services provided to Mr. Nevils in treatment of his accident related injuries.

28. The United States Supreme Court held in *Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677 (2006) that FEHBA's preemption clause – 5 U.S.C. § 8902(m)(1) – does not apply to subrogation or reimbursement rights of an insurer. Therefore, Missouri state law applies to the reimbursement rights of an insurer.

29. Missouri law has long prohibited subrogation in personal injury claims and does not allow for reimbursement to health insurers for payments made for treatment received related to a personal injury. This prohibition on subrogation of personal injury claims exists even if there is a contractual provision in the health benefit plan that purports to allow for such subrogation rights.

30. There is no Federal provision that provides a reimbursement/subrogation right to such medical benefits paid pursuant to a FEHBA plan. Accordingly, such reimbursement rights are controlled by Missouri law, which expressly prohibits subrogation of health care benefits paid in connection with personal injury settlements.

31. Upon information and belief, despite being aware and informed of their lack of entitlement to reimbursement, the Defendants continued to pursue payment of unlawful reimbursement from Plaintiff's personal injury settlement.

32. On or about, January 29, 2010, Mr. Nevils remitted $6,592.24 to Defendant GHP by and through its agent, Defendant ACS Recovery.

33. Subsequently, Defendants converted the funds from Mr. Nevils' personal injury settlement.

CLASS ACTION ALLEGATIONS

34. This action is brought as a plaintiff class pursuant to Missouri Rule of Civil Procedure 5.08. Plaintiff brings this action on her own behalf and all others similarly situated, as representative of the following class.

> All Missouri residents who received health insurance coverage through a FEHBA plan

who have had a right of reimbursement asserted against a personal injury claim or settlement by Defendants and such reimbursement was paid to Defendants within five years of the filing date of this Petition.

35. The particular members of the class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of the Defendants. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

36. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class members. The only material difference between the Class members' claims is the exact monetary amount to which each member of the Class is entitled. The principal common issues include, but are certainly not limited to the following:

(a) Whether Defendants entered into express and/or implied agreements with the federal government providing for reimbursement/subrogation rights on personal injury claims;

(b) Whether a provision for reimbursement/subrogation rights on personal injury

claims contained in such a statement of benefits would be unenforceable under Missouri law;

(c) Whether Defendants employ a policy and business model of unlawfully asserting reimbursement/subrogation rights to which they are not entitled;

(d) Whether Defendants unlawfully asserted reimbursement/subrogation rights against personal injury claims/settlements in violation of Missouri law;

(e) Whether the Defendants utilized aggressive collection practices to collect reimbursement of funds from the Plaintiff and the Class to which they were not entitled under applicable law;

(f) Whether such uniform practices asserted against all class members were unlawful and, thereby, unjustly profited the Defendants at the Plaintiff's and the Class members' expense;

(g) Whether Defendants have been unjustly enriched at the Plaintiff's and the Class members' expense through the misconduct described herein;

(i) Whether Defendants violated the Missouri Merchandising Practices Act through the above described misconduct;

(k) Whether Defendants should be enjoined from continuing their unfair, predatory, and abusive conduct;

37. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories.

38. Plaintiff will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel in complex class actions. Counsel is committed to the vigorous prosecution of this action.

39. Certification of a plaintiff class is appropriate in that Plaintiff and the Class members seek monetary damages, common questions predominate over any individual questions, and a plaintiff class action is superior for the fair and efficient adjudication of this controversy. A plaintiff class action will cause an orderly and expeditious administration of the Class members' claims and economies of time, effort and expense will be fostered and uniformity of decisions will be ensured. Moreover, the individual class members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against the likes of the Defendants.

40. Alternatively, certification of a plaintiff class is appropriate in that inconsistent or varying adjudications with respect to individual members of the Class would establish incompatible standards of conduct for the Defendants or adjudications with respect to individual members of the Class as a practical matter would be dispositive of the interests of the other members not parties to the adjudications or would substantially impair or impede their ability to protect their interests.

41. Defendants have acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corre-

sponding declaratory relief with respect to the class as a whole.

COUNT I
(Violation of the Missouri Merchandising Practices Act)

42. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

43. RSMo. § 407.020 prohibits the use of any "deception, fraud, false pretense, false promise, misrepresentation, unfair practice or the concealment, suppression, or omission of any material fact in connection with the sale or advertisement of any merchandise in trade or commerce. . ."

44. An "unfair practice" is defined by Missouri law, 15 CSR 60-8.020, as any practice which:

(A) Either-

1. Offends any public policy as it has been established by the Constitution, statutes or common law of this state, or by the Federal Trade Commission, or its interpretive decisions; or

2. Is unethical, oppressive or unscrupulous; and

(B) Presents a risk of, or causes, substantial injury to consumers.

45. An "unfair practice" is further defined by Missouri law, 15 CSR 60-8.040, accordingly:

(1) It is an unfair practice for any person in connection with the advertisement or sale of merchandise to violate the duty of good faith in solicitation, negotiation and per-

formance, or in any manner fail to act in good faith.

46. "Merchandise" is defined by the MPA, at RSMo. § 407.010(4), to include the providing of "services" and, therefore, encompasses the providing for the administration of medical care and billing for the same.

47. "Person" is defined by the MPA, at RSMo. § 407.010(5), to include any "for-profit or not-for-profit corporation. . .company. . .business entity or association, and any agent, employee, salesman, partner, officer, director, member, stockholder, associate, trustee or cestui que trust thereof."

48. The above described behavior, misconduct, and unlawful acts of the Defendants violate the Missouri Merchandising Practices Act by, among other things, constituting an unfair practice and breach of the duty of good faith as required under the Act.

49. As a result of the above described wrongful acts, Plaintiff and the Class members have suffered damages.

COUNT II
(Unjust Enrichment)

50. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

51. As alleged above, the Defendants have engaged in a pattern and practice of unlawfully subverting the financial interests of Plaintiff and the Class for their own pecuniary gain.

52. Defendants have been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled to and received in violation of Missouri law.

53. Said benefits were unlawfully obtained to the detriment of Plaintiff and the Class members.

54. Allowing Defendants to retain the aforementioned benefits violates fundamental principles of justice, equity, and good conscience.

COUNT III
(Conversion)

55. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

56. As alleged above, Defendants have engaged in a pattern and practice of unlawfully depriving the Plaintiff and the Class of certain property.

57. Plaintiff and the Class were legally entitled to the property in question when the Defendants deprived Plaintiff of the property.

58. Defendants acted purposefully and wrongfully in dispossessing Plaintiff and the Class of the property in question.

59. Such unfair misconduct by Defendants caused economic injury and other damages to the Plaintiff and the Class.

COUNT IV
(Injunctive Relief)

60. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

61. As set forth herein, Defendants have improperly taken the property of Plaintiff and the Class Members for its own pecuniary benefit as prohibited by law.

62. Upon information and belief, Defendants continue the unlawful practices enumerated above

causing irreparable harm to the Plaintiff and the Class members.

63. As set forth herein, Plaintiff and the Class have a high probability of success on the merits of this action.

64. Accordingly, Defendants should be enjoined from continuing to perpetuate such predatory and unfair practices on consumers, such as Plaintiff and the Class.

PRAYER FOR DAMAGES AND RELIEF

WHEREFORE, Plaintiff, on behalf of himself and all members of the Class respectively prays for judgment against the Defendants as follows:

a) For an order certifying that this action may be maintained as a class action and appointing Plaintiff and his counsel, to represent the Class;

b) For a declaration that the Defendants' actions violated the Plaintiff's and the Class members' rights under Missouri law as plead herein;

c) For all actual damages, punitive damages, statutory damages, penalties, and remedies available for the Defendants' violations of Plaintiff's and the Class members' rights under Missouri law;

d) For a declaration that Defendants, through the actions and misconduct as alleged above, have been unjustly enriched and an order that Defendants disgorge any unlawfully gained proceeds;

e) For pre-judgment interest as provided by law;

f) For post-judgment interest as provided by law;

g) For a permanent injunction enjoining Defendants from engaging in the unlawful practices as enumerated above;

h) For an award to Plaintiff and the Class their reasonable attorneys' fees;

i) For an award to Plaintiff and the Class of their costs and expenses of this action;

j) For such other and further relief as the Court may deem necessary and proper.

Respectfully submitted,

s/

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No. SC93134
St. Louis County Circuit Court Case No. 11SL-CC00535-01

In the Supreme Court of Missouri

May Session, 2016

Jodie Nevils,

Appellant,

v. APPEAL FROM THE CIRCUIT COURT OF ST. LOUIS COUNTY

Group Health Plan, Inc., and ACS Recovery Services, Inc.,

Respondents.

Now at this day come again the parties aforesaid, by their respective attorneys, and the Court here being now sufficiently advised of and concerning the premises, doth consider and adjudge that the judgment aforesaid, in form aforesaid, by the said Circuit Court of St. Louis County rendered, be reversed, annulled and for naught held and esteemed, and that the said Appellant be restored to all things which he has lost by reason of said judgment. It is further considered and adjudged by the court that the said cause be remanded to the said Circuit Court of St. Louis County for further proceedings to be had therein, in conformity with the opinion of this court herein delivered; and that the said Appellant recover against the said Respondents costs and charges herein expended, and have execution therefor.

(Opinion filed.)

STATE OF MISSOURI-Sct.

I, BILL L. THOMPSON, Clerk of the Supreme Court of Missouri, certify that the foregoing is a full, true and complete transcript of the judgment of said Supreme Court, entered of record at the May Session thereof, 2016 and on the 3rd day of May 2016, in the above entitled cause.

Given under my hand and seal of said Court at the City of Jefferson, this 19th day of May 2016.

s/ _____
Clerk

s/ _____
Deputy Clerk

[*1]

86TH CONGRESS *1st Session*

HOUSE OF REPRESENTATIVES

REPORT No. 957

GOVERNMENT EMPLOYEES HEALTH BENEFITS PROGRAM

AUGUST 20, 1959.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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MR. MURRAY, from the Committee on Post Office and Civil Service, submitted the following

REPORT

[To accompany S. 2162]

The Committee on Post Office and Civil Service, to whom was referred the bill (S. 2162) to provide a health benefits program for Government employees, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

AMENDMENT

The amendment proposed by the committee to S. 2162 strikes out all after the enacting clause and inserts in lieu thereof a substitute text which appears in italic type in S. 2162, as reported by the committee of the House. A discussion of the effect of this proposed amendment is contained in the explanation of the bill, as reported.

STATEMENT

PURPOSE

The general purpose of this legislation is to facilitate and strengthen the administration of the activities of the Government generally and to improve personnel administration in the Government by providing a measure of protection for civilian Government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive Government-wide program of insurance for Federal employees and their dependents, the costs of which will be shared by the Government, as employer, and its employees.

At the present time, a wide gap exists between the Government, in its capacity of employer, and employers in private enterprise, with [*2] respect to health benefits for employees. Enlightened, progressive private enterprise almost universally has been establishing and operating contributory health benefit programs for its employees. Until now, the Government has made scant progress in this area.

This bill is designed to close the gap which now exists and bring the Government abreast of most private employers. It will enable Government employees to purchase protection, at a cost which is within their means, from the unanticipated and usually oppressive costs of medical care and treatment in the event of sickness or injury, as well as the often crushing expense of so-called catastrophic illness or serious injury. Availability of this health protection program to Government employees will be of material assistance in improving the competitive position of the Government with respect to private enterprise in the recruitment and retention of competent civilian

personnel so urgently needed to assist in maintaining and improving our strong national defense and in the operation of other essential Government programs.

The addition of the health insurance program provided by the bill to the existing fringe benefits package for Government employees—which currently includes retirement and survivor annuities, group life insurance, annual and sick leave, compensation for job-connected injury or death, and other benefits—will fill a long, keenly felt need and will place the Government on a substantially equal level with progressive industry in respect to employee fringe benefits.

Legislation to establish a health benefits program for Federal employees has been before the Post Office and Civil Service Committee in each Congress beginning with the 83d. Hearings were held in 1956 on an administration proposal to provide Federal employees protection against the bankrupting expenses of extended catastrophic illness or injury, with the Government sharing the cost. The reported bill incorporates the outstanding feature of that plan—"major medical" protection against the expense of catastrophic illness or injury—and, in addition, provides protection for basic health needs. Thus the bill affords Federal employees an opportunity to obtain comprehensive insurance for health services at moderate cost.

The urgent need for a joint Government-employee health benefits program is emphasized by the fact that there is widespread and increasing recognition on the part of the public that both basic health and major medical insurance coverages are essential to protect wage-earners and their families.

In 1940, approximately 4 million individuals were enrolled in basic hospital plans; at the beginning of 1959 the number of individuals who had this protection had skyrocketed to 123 million—70 percent of the population. Similar spectacular increases have been recorded in surgical and regular medical programs. In the comparatively new field of major medical insurance, participation in plans offering this protection has virtually exploded from 700,000 in 1952 to 17 million in 1959. It is a source of concern to this committee that no more than a relative handful of Federal employees now have such major medical coverage. This extremely important protection will be made available by the reported bill, along with the more generally prevalent basic coverage which now is held by approximately 70 percent of Federal employees.

[*3] COMMITTEE REVIEW OF PROGRAM

The committee emphasizes that the health benefits program provided by this legislation represents an entirely new area of Federal employees' fringe benefits in which the Government is without previous experience, and that extreme care will be necessary, particularly in the initial stages, to protect both the Government and its employees. The committee intends to conduct a continuing review of the operation of the program in order to carry out its responsibilities under section 136 of the Legislative Reorganization Act of 1946.

SUMMARY OF MAJOR PROVISIONS

The reported bill makes basic and catastrophic health protection available to approximately 2 million Federal employees and their dependents. Employees will have free choice among health benefits

plans in four major categories, including (1) a Government-wide service benefit plan, such as is offered by Blue Cross-Blue Shield, (2) a Government-wide indemnity benefit plan, such as is currently offered by several insurance companies, (3) one of several employee organization plans, such as the present health plans of the National Association of Letter Carriers and the National Federation of Post Office Clerks, and (4) a comprehensive medical plan, which may be either a group-practice prepayment plan (such as the Kaiser Foundation plan in California and the Group Health Association plan in Washington, D.C.) or an individual-practice prepayment plan (such as the Group Health Insurance plan in New York). The Government-wide service benefit plan and the Government-wide indemnity benefit plan each will include at least two levels of benefits.

The reported bill retains the provisions of the Senate-passed bill (1) providing for 50 percent contribution by the Government to subscription charges and (2) establishing biweekly maximum contributions of $1.75 for an individual employee, $4.25 for an employee and family, and $2.50 for a female employee and family including a nondependent husband.

Employees will be eligible for enrollment in health benefits plans without having to pass any physical examination and, in the event of their separation from Government service, may convert their coverage to a private health benefits plan without undergoing any physical examination. It is intended that each of the foregoing plans will provide a wide range of hospital, surgical, medical, and related benefits designed to afford the employees full or sub-

stantially full protection against expenses of both common and catastrophic illness or injury.

Responsibility and authority for administration of the health benefits program in the interest of both the employees and the Government is vested in the U.S. Civil Service Commission. The Commission will execute contracts with the Government-wide service plan carrier and the Government-wide indemnity plan carrier and will make suitable arrangements to place the other types of plans in effect through appropriate contracts or agreements.

Provision is made for the prime insurer under the Government-wide indemnity benefit plan to reinsure with such other qualified companies as may elect to participate, in accordance with an equitable formula. [*4] Similar provision is made for the prime carrier under the Government-wide service benefit plan to allocate its rights and obligations under its contract among such of its affiliates as may elect to participate.

No person will be excluded from participation in the health benefits program because of race, sex, health status, or (at the time of first opportunity to enroll) age.

With respect to the service benefit plan and the indemnity benefit plan, the reported bill requires the Commission to enter into contracts which call for premium rates that are competitive with those generally charged for a new group health insurance sold to large employers. For the premiums agreed upon, the Commission is charged with negotiating the best possible basic health and major medical benefits. These provisions are designed to assure maximum

health benefits for employees at the lowest possible cost to themselves and to the Government.

The Government will contribute 50 percent to the subscription charge for each enrolled employee, but not more than certain amounts which the Commission may prescribe from time to time subject to (1) biweekly minimums of $1.25 for an individual employee or annuitant, $3 for an employee or annuitant and family, and $1.75 for a female employee and family including a nondependent husband, and (2) biweekly maximums of $1.75 for an individual employee, $4.25 for an employee or annuitant and family, and $2.50 for a female employee and family including a nondependent husband. The provisions for contributions are related to the service benefit plan and the indemnity benefit plan authorized by section 4 of the bill, thus permitting each employee to exercise independent judgment and obtain the plan which best suits his or her individual needs or family circumstances.

The bill provides for setting aside portions of total contributions (1) not exceeding 1 percent for administrative expenses, and (2) not exceeding 3 percent to provide a contingency reserve or margin for adjustment based on experience without seeking further legislation.

The Commission will make available to each employee eligible to enroll in a health benefits plan information which will enable the employee to exercise an informed choice among the various plans. Each employee will be issued an appropriate certificate summarizing the benefits under the plan selected.

The bill authorizes the Chairman of the Civil Service Commission to appoint an advisory commit-

tee of five members, comprising employees enrolled under the act and elected officers of employee organizations. This committee (which will perform a solely advisory function) replaces the Advisory Council which would have been provided by the Senate bill.

The bill omits those parts of the Senate bill which would have (1) established a Bureau of Retirement and Insurance in the Civil Service Commission to administer the health benefits program along with the retirement and life insurance programs, and (2) required prior submission of health benefits contracts to the Post Office and Civil Service Committees of the Senate and the House of Representatives. In the judgment of the committee, the assignment of duties in connection with administration of the program should be left to the [*5] discretion of the Civil Service Commission, which is responsible for success of the program. The committee is convinced that the prior submission of contracts would have tended to impede and interfere with progress in the establishment and operation of the program.

COST

On the basis of the formula, provided by section 7 of the reported bill, for a 50 percent Government contribution subject to certain limitations, the cost of the program for the first year of operation is estimated at $214 million, of which approximately one-half will be paid by the Government.

ADMINISTRATIVE REPORTS

The reports of the Director of the Bureau of the Budget and the Chairman of the U.S. Civil Service Commission (directed to S. 2162 as passed by the Senate and submitted before the committee amendment was drafted) recommend approval of a health

benefits program identical in principle to the program which will be established by the bill, as reported by this committee, except that such reports favor a Government contribution of 33½ percent in lieu of 50 percent as authorized by the reported bill. The Post Office Department, the Department of Health, Education, and Welfare, the Department of Defense, and the Comptroller General of the United States also submitted reports favorable to the principles of the reported bill.

The committee points out that the Civil Service Commission, the Bureau of the Budget, major employee organizations, and leading companies and associations which now provide health benefits and will participate in this program, have agreed to the terms of the reported bill, in a spirit of compromise and cooperation, in order that an effective and financially sound Government employees health benefits program may become a reality at the earliest possible time. The committee desires to express its appreciation for this cooperation and joint endeavor to bring about a result in the general interest of the Government and all parties concerned. It is believed that the final agreement represented by the reported bill will receive overwhelming approval by Federal employees, full cooperation by the companies and associations which expect to participate, and support of the Government departments and agencies concerned.

The text of the reports of the Bureau of the Budget, the Civil Service Commission, the Department of Defense, the Department of Health, Education, and Welfare, and the General Accounting Office appear immediately following the explanation of the bill, as reported.

EXPLANATION OF THE BILL, AS REPORTED

SHORT TITLE

The first section of the bill creates a short title which permits the provisions of this legislation to be conveniently cited as the "Federal Employees Health Benefits Act of 1959."

[*6] DEFINITIONS

Section 2 defines the technical terms used throughout the act, as follows:

Subsection (a) defines the term "employee" to include an appointive or elective officer or employee in or under the executive, judicial, or legislative branches of the U.S. Government and an employee of the District of Columbia government. Included within the definition are Members of Congress, the Official Reporters of Debates of the Senate and their employees, and employees of Gallaudet College. The definition of the term "employee" does not include members of the Armed Forces ("uniformed services") and noncitizen employees whose permanent duty stations are located outside the United States. Also excluded are employees of certain corporations which are under the supervision of the Farm Credit Administration, of which corporations any member of the board of directors is elected or appointed by private interests.

This definition will operate to provide coverage under the bill to the same groups of employees who are covered under the Federal Employees' Group Life Insurance Act of 1954, as amended, except that employees of the Tennessee Valley Authority, who have been specifically excluded from the definition, will not be covered. This exclusion was made at the request of the Tennessee Valley Authority because em-

ployees of the Authority have their own contributory health benefits program which has been operating successfully.

Subsection *(b)* defines the term "Government" as meaning the Government of the United States of America to distinguish it from State and local governments.

Subsection *(c)* defines the term "annuitant" to include—

(1) an employee who retires on or after the effective date (July 1, 1960), mentioned in section 15, under the Civil Service Retirement Act or other retirement system for civilian employees, on an immediate annuity after 12 or more years of service or for disability;

(2) a member of a family who receives an immediate annuity as the survivor of a retired employee described in paragraph (1), or an employee who dies after completing 5 or more years of service;

(3) an employee who receives benefits under the Federal Employees' Compensation Act as a result of illness or injury to himself and who because of the illness or injury is determined by the Secretary of Labor to be unable to return to duty; and

(4) a member of a family who receives monthly compensation as the surviving beneficiary of—

(A) an employee who dies of an illness or injury compensable under the Federal Employees' Compensation Act after 5 or more years of service, or

(B) a former employee who dies while receiving compensation benefits and is held by the Secretary of Labor to have been unable to return to duty.

Subsection (*d*) defines the term "member of family" to include—

an employee's or annuitant's spouse;

his unmarried children under age 19, including—

(A) an adopted child, and

(B) a stepchild or recognized natural child who lives with him in a regular parent-child relationship; and [*7]

(C) his unmarried children, regardless of age, who are incapable of self-support because of a disability that existed prior to their reaching the age of 19.

Subsection (*e*) defines the term "dependent husband" to mean a husband who is incapable of self-support by reason of mental or physical disability which can be expected to continue for more than 1 year.

Subsection *(f)* defines the term "health benefits plan" as meaning essentially a group insurance policy, contract, agreement, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services.

Subsection (*g*) defines the term "carrier" to include a voluntary association, corporation, partnership, or other nongovernmental organization which provides, pays for, or reimburses the cost of health services under group insurance contracts, agreements, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier. The definition includes a health benefits plan duly sponsored or underwritten by an employee organization.

Subsection (*h*) defines the term "Commission" as meaning the U.S. Civil Service Commission, to which is assigned the responsibility of administering this legislation.

Subsection (*i*) defines the term "employee organization" to include an association or other organization of employees which—

(A) is national in scope or

(B) in which membership is open to all employees of a department or agency of the Government who are eligible to enroll in a health benefits plan

and which on or before December 31, 1959, applies to the Commission for approval of a plan which it sponsors or underwrites.

In addition to the health benefits plans provided by national employee labor organizations, this language would include employee organization sponsored plans such as those of the Federal Bureau of Investigation, the National Security Agency, the U.S. citizen employees of the Panama Canal, the Foreign Service, the Central Intelligence Agency, and the Postal Hospital Association of St. Louis.

ELECTION OF COVERAGE

Section 3 provides generally for election of health benefits plans by employees.

Subsection (*a*) permits an eligible employee to enroll, either as an individual or for self and family, in a health benefits plan approved by the Civil Service Commission. This subsection authorizes the Commission (1) to prescribe regulations fixing the time, manner, and conditions of eligibility for enrollment and (2) to exclude employees from enrolling

on the basis of the nature and type of their employment or conditions pertaining thereto such as, but not limited to, short-term appointments, seasonal or intermittent employment, and employment of like nature. However, no employee may be excluded by the Commission's regulations solely on the basis of the hazardous nature of his job.

Subsection (*b*) permits an annuitant to continue his coverage after he retires if he was enrolled in a health benefits plan under the act for a period of not less than (A) the 5 years of service immediately [*8] preceding retirement or (B) the full period or periods of service between the date he first becomes eligible to enroll in a plan and the date on which he becomes an annuitant, whichever is shorter. This subsection also permits the survivor of a deceased employee or annuitant to continue his coverage if the survivor was enrolled as a member of the family at the time of the employee's or annuitant's death.

Where a husband and wife are both Federal employees, subsection (c) permits either one to enroll individually or to enroll for self and family and prohibits any person from enrolling both as an employee or annuitant and as a member of the family.

Subsection (*d*) permits an employee or annuitant to change from individual to family coverage or vice versa at such time and under such conditions as the Commission may prescribe.

Subsection (*e*) permits an employee or annuitant to transfer his enrollment from one health benefits plan to another at such time and under such conditions as the Commission may prescribe.

HEALTH BENEFITS PLANS

Section 4 authorizes the Commission to contract for or approve the following health benefits plans:

(1) One Government-wide service benefit plan of the type commonly provided by Blue Cross-Blue Shield under which payment for medical services is made, insofar as possible, under contracts with hospitals, physicians, and other vendors of medical services. Where such payment is impracticable, it will be made directly to the employee.

(2) One Government-wide indemnity benefit plan such as is commonly provided by commercial insurance companies. Under this type of plan payment for medical services may be made directly to the employee or directly to the vendor of the medical services.

(3) Employee organization plans which are sponsored or underwritten by employee organizations. To be eligible under the bill, the organization which sponsors or underwrites the plan must have had in operation a plan which provided health benefits to its members on July 1, 1959. Employees will be able to enroll in these employee organization plans only if at the time of enrollment they are members of the organization.

(4) Two types of comprehensive medical plans—(A) group-practice prepayment plans and (B) individual-practice prepayment plans.

The Government-wide service benefit plan and the Government-wide indemnity benefit plan will each offer two options providing varying levels of benefits at varying subscription charges so that every employee will have an unrestricted choice between the service type plan and the indemnity type plan

and, within each plan, between benefits and subscription charges which best suit his family circumstances and his ability to pay.

An employee who belongs to an association which sponsors an employee organization plan will have the additional choice of enrolling in his association's plan. Employees who are located in areas in which a group-practice prepayment plan or an individual-practice prepayment plan operates will have the further choice of enrolling in such a comprehensive medical plan.

[*9] TYPES OF BENEFITS

Section 5 stipulates that the benefits to be provided under the plans described in section 4 may be of the following types:

(1) Service benefit plan—
  (A) hospital benefits.
  (B) surgical benefits.
  (C) in-hospital medical benefits.
  (D) ambulatory patient benefits.
  (E) supplemental benefits.
  (F) obstetrical benefits.

(2) Indemnity benefit plan—
  (A) hospital care.
  (B) surgical care and treatment.
  (C) medical care and treatment.
  (D) obstetrical benefits.
  (E) prescribed drugs, medicines, and prosthetic devices.
  (F) other medical supplies and services.

(3) Employee organization plans—

Benefits of the types described in paragraph (1) or (2) or both.

(4) Comprehensive medical plans—

Benefits of the types described in paragraph (1) or (2) or both.

The general effect of section 6 is to authorize and require the Civil Service Commission to take appropriate action to contract, or to make other arrangements, for health-benefits plans.

CONTRACTING AUTHORITY

Subsection (*a*) authorizes the Civil Service Commission to negotiate contracts with qualified carriers offering plans described in section 4. The subsection requires each such contract to be for a uniform term of at least 1 year and permits the contract to be made automatically renewable from term to term in the absence of notice of termination by either party.

Paragraph (1) of subsection (b) requires the prime carrier for the indemnity benefit plan to be a company which is licensed to issue group health insurance in all the States and the District of Columbia.

Under the related authority to prescribe minimum standards for carriers, vested in the Civil Service Commission by subsection (d), it is expected that one of the standards for the prime indemnity carrier will be the volume of group health insurance business it has handled in the past. The Commission is expected to choose as a prime carrier a company that has by the volume of its operations demonstrated the experience and capacity necessary to handle what will undoubtedly be the largest policy of its kind in the world. In addition to requiring licensing in all the States and the District of Columbia, the Commission will presumably apply some volume-of-business test, such as requiring that the carrier selected shall, in the most recent year for which data

are available, have made at least 1 percent of all group health insurance benefit payments in the United States.

[*10] Paragraph (2) of subsection (*b*) requires the prime carrier of the indemnity benefit plan to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance payments in the United States during the latest year for which such information is available. The reinsurance formula is to be determined by the carrier and approved by the Commission. Under paragraph (2) the prime carrier for the service benefit plan is similarly required to allocate its rights and obligations among such of its affiliates as may elect to participate, in accordance with an equitable formula which the carrier and its affiliates will determine and which the Commission will approve.

This practice of reinsuring and allocating rights and obligations follows closely the policy laid down by the Congress in the Federal Employees' Group Life Insurance Act of 1954 and ensures that all qualified companies and organizations which are engaged in providing protection against the cost of health services will share equitably in the contracts to be negotiated under this act, if they desire to do so.

Subsection (*c*) requires that any contract negotiated by the Civil Service Commission shall contain a detailed statement of benefits offered and include such maximums, limitations, exclusions and other definition of benefits as the Commission may deem necessary or desirable.

Subsection (*d*) authorizes the Civil Service Commission to prescribe regulations fixing minimum

standards for participating health benefits plans and for carriers offering such plans.

Subsection (*e*) prohibits the Civil Service Commission from entering into any contract or approving any plan which excludes employees or annuitants, or members of their families, because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

Subsection (*f*) requires each plan approved by the Commission to permit an employee or annuitant whose enrollment in the plan is terminated, other than by his voluntary cancellation of enrollment, to convert from group coverage to individual coverage. It is expected that when the group coverage of an employee or annuitant terminates, he will have continued temporary protection for 31 days without current contributions so that he may have reasonable opportunity to convert to individual coverage and thus avoid an interruption in his protection against the cost of health services. The terms or conditions under which the employee or annuitant may convert will be prescribed by the carrier and approved by the Civil Service Commission and the employee will have to pay the periodic charges of the converted coverage directly to the carrier.

Subsection (*g*) requires that the converted coverage shall, at the option of the employee or annuitant, be noncancellable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

Subsection (*h*) stipulates that the premiums to be charged by the carriers for approved health benefits plans shall reasonably and equitably reflect the cost of the benefits provided. The subsection requires that the premiums for the service benefit plan and

the indemnity benefit plan be determined on a basis which, in the judgment of the Civil Service Commission, is consistent with the lowest schedule of basic rates generally charged for new group health benefits plans [*11] issued to large employers. This subsection further requires that premium rates determined for the first contract term shall be continued for subsequent contract terms except that they may be readjusted for any subsequent term based on past experience and benefit adjustments under the subsequent contract. Any readjustment in rates is required to be made in advance of the contract term in which the new rates will apply and on a basis which, in the judgment of the Commission, is consistent with the general practice of carriers which issue group health benefits plans to large employers.

The effect of subsection (*h*) is to make certain that the premiums which the Government will have to pay for the service benefit plan and the indemnity benefit plan will not be more costly than those charged by the industry to other large employers.

CONTRIBUTIONS

Section 7 provides for contributions by the Government and by employees to subscription charges.

Paragraph (1) of subsection (*a*) specifies the Government's contributions to the subscription charge for each enrolled employee and annuitant as the lesser of (A) 50 percent of the subscription charge or (B) such other amounts as the Commission prescribes.

The amounts which the Commission may prescribe, in accordance with clause (B), above, must not (i) be less than $1.25 or more than $1.75 biweekly for an individual who is enrolled for self alone, (ii) be

less than $3 or more than $4.25 biweekly for an individual who is enrolled for self and family, or (iii) be less than $1.75 or more than $2.50 biweekly for a female employee who enrolls for self and family if the family includes a nondependent husband.

Paragraph (2) of subsection (a) authorizes the withholding from an individual's salary or annuity of the difference between the total subscription charge of the plan in which he is enrolled and the Government's contribution to the subscription charge. The employees' contributions will be made through payroll deductions, as is the case with respect to employees' contributions under the Civil Service Retirement Act and the Federal Employees' Group Life Insurance Act of 1954.

Paragraph (3) authorizes the Civil Service Commission to adjust the contributions of the Government and of the employees and annuitants to a particular plan whenever past experience indicates that such an adjustment is warranted or whenever there is a change in benefits offered by the plan. Any such adjustment must preserve the same ratio between the Government's and employee's or annuitant's contribution as existed originally, with the one exception that the Government's contribution cannot be adjusted to a biweekly amount which is more than the $1.75, $4.25, or $2.50 specified in subsection (*a*)(1).

The net effect of this provision is that the Commission will prescribe the maximum contribution which the Government will make to each approved health benefits plan and so be able to control the total cost of the program to the Government.

It is expected that the Government contributions prescribed by the Commission will be 50 percent of

the subscription charge to the approved plans in which most employees are enrolled. Thus the [*12] Government and the employee or annuitant will each contribute 50 percent of the subscription charge.

There may be some plans or options within plans which will provide benefits superior to the benefits under other plans or options and for which the subscription charge per enrollment will exceed the sum of the prescribed maximum Government contribution plus a matching contribution from the employee or annuitant. Where an employee chooses to enroll in such a superior-benefit plan or option, the excess portion of the subscription charge will be withheld from his salary.

Any adjustment in contribution rates must, within the specified limits, preserve the ratio which originally existed between the employee's or annuitant's contribution and the Government's contribution. If in the future an adjustment will (because of the maximums imposed on the Government's contribution) result in destroying this ratio, it is contemplated that the Civil Service Commission will call the matter to the attention of the Congress in advance so that the legislation can be amended to increase the maximum Government contributions if the Congress wishes.

Subsection (*b*) authorizes the Civil Service Commission to continue an employee's coverage for a period of up to 1 year (exclusive of any temporary extension of coverage) while he is in a leave-without-pay status. Because the employee will not be drawing any pay during this period, no contributions can be withheld from his salary and, therefore, the Commission is authorized to waive both the employee's and the Government's contributions while the employee is in a leave-without-pay status.

Subsection (*c*) directs that the Government's contribution toward the cost of the program be paid from the following sources:

(1) For most employees, from the appropriation or fund which is used for the payment of their salaries.

(2) In the case of an elected official, from the appropriation or fund which is available for payment of other salaries of the same office or establishment.

(3) In the case of an employee in the legislative branch whose salary is paid by the Clerk of the House of Representatives, from the contingent fund of the House.

Subsection (*d*) directs the Civil Service Commission to provide for the conversion of the biweekly contribution rates to weekly, monthly or other rates in the case of individuals who are paid on other than a biweekly basis and permits the converted rate to be adjusted to the nearest cent.

EMPLOYEES' HEALTH BENEFITS FUND

Subsection (*a*) of section 8 creates an employees health benefits fund, to be administered by the Civil Service Commission, which is made available without fiscal year limitation for the payment of all premiums to approved health benefits plans and into which all contributions of employees, annuitants and the Government shall be paid.

Subsection (6) requires that portions of the contributions made by employees, annuitants, and the Government shall be regularly set aside in the fund as follows:

(1) A percentage, not to exceed 1 percent of all such contributions, determined by the Commission as reasonably adequate to pay its administrative expenses under this bill. [*13]

(2) For each health benefits plan a percentage, not to exceed 3 percent of the contributions for such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. It is expected that these contingency reserves will be available to defray anticipated increases in future premiums and it is hoped that their use in this manner will postpone for a reasonable period of time the necessity of increases in contribution rates. Authorization is also contained in this subsection for applying the contingency reserves to reduce the contributions of employees and the Government or to increase the benefits provided by the plan from which the reserves are derived. It is required that the contingency reserves set aside for each plan will be used for the purposes mentioned above with respect to that plan only.

Subsection (*c*) authorizes the Secretary of the Treasury to invest any of the moneys in the employees health benefits fund in interest bearing obligations of the United States and to sell such obligations for the purposes of the fund. All interest derived from these investments and the proceeds from the sale of obligations will become a part of the fund.

ADMINISTRATIVE EXPENSES

Subsection (*a*) of section 9 authorizes the expenditure from the employees' life insurance fund for the fiscal years 1960 and 1961, without regard to limitations on that fund, of such sums as may be necessary to pay the administrative expenses of the

Civil Service Commission in carrying out the provisions of the Federal Employees Health Benefits Act of 1959. The subsection requires that reimbursement for sums so expended be made from the employees' health benefits fund to the employees' life insurance fund, together with interest at a rate to be determined by the Secretary of the Treasury.

Subsection (*b*) makes the employees' health benefits fund available (1) to reimburse the employees' life insurance fund, as indicated and (2), within such limitations as may be specified annually by the Congress, to pay the expenses of the Commission in administering this legislation for the fiscal year 1962 and subsequent years.

ADMINISTRATION

Subsection (*a*) of section 10 authorizes the Civil Service Commission to promulgate such regulations as may be necessary to give effect to the intent and purposes of the Federal Employees Health Benefits Act of 1959.

Subsection (*b*) requires the Civil Service Commission to specify in its regulations the beginning and ending dates of coverage of employees and annuitants and members of their families. The subsection permits the Commission, by regulation, to grant a temporary extension of coverage upon cancellation (other than voluntary cancellation) of enrollment. Where the cancellation is for reasons other than the death of the employee or annuitant, it is expected that the temporary extension of coverage will continue for 31 days. Where the cancellation is on account of the death of the employee or annuitant, this subsection permits a temporary extension of coverage for members of the family for as long as 90 days after

the end of the pay period or month in which the death of the employee or annuitant occurred. In any case, it is intended that the temporary extension of coverage will be [*14] without current contributions by the employee or annuitant, or members of his family, and by the Government.

Subsection (*c*) provides that an employee enrolled under this legislation who is removed or suspended without pay and later reinstated or restored to duty because the removal or suspension was unjustified or unwarranted shall have his coverage restored so that he may enjoy the same benefits as if removal or suspension had not occurred.

Subsection (*d*) requires that the Civil Service Commission shall make available to each employee such information as may be necessary to enable him to exercise an informed choice among the various plans available. This information with respect to the Government-wide service benefit plan and the Government-wide indemnity benefit plan must be in a form acceptable to the Commission and will be developed by the Commission after consultation with the carriers. It is expected that information with respect to the employee organization plans and the comprehensive medical plans will be prepared and distributed by the respective carriers; however, this information must also be approved by the Commission. Each employee who enrolls in a health benefits plan will be issued an appropriate certificate summarizing the services or benefits provided by the plan. These certificates will also have to be approved by the Commission.

STUDIES, REPORTS, AND AUDITS

Subsection (*a*) of section 11 stipulates that the Civil Service Commission shall make a continuing study of the operation and administration of this legislation, including surveys and reports on health benefits plans available to employees and on the experience of such plans. It is expected that in making this study the Commission will include any instances of apparent overutilization of hospital facilities and any instances of apparently excessive charges by purveyors of health services.

Subsection (*b*) requires carriers to furnish such reports as the Civil Service Commission determines to be necessary to enable it to carry out its functions under this legislation and permits the Commission and representatives of the General Accounting Office to examine any records of the carriers which either the Commission or the General Accounting Office deem to be pertinent to the purposes of this legislation.

Subsection (*c*) requires Government departments, agencies, and independent establishments to keep such records, make such certifications, and furnish the Civil Service Commission such information and reports as may be necessary to enable the Commission to carry out its functions under the legislation.

REPORTS TO CONGRESS

Section 12 requires the Commission to transmit to the Congress an annual report concerning the operation of the Federal Employees Health Benefits Act of 1959.

ADVISORY COMMITTEE

Section 13 requires the Chairman of the Civil Service Commission to appoint a committee composed of five members, who will serve [*15] without compensation, to advise the Commission regarding matters of concern to employees under this legislation. Each member of the committee will be an employee enrolled under this legislation, or an elected officer of a national employee organization.

JURISDICTION OF COURTS

Section 14 gives the district courts of the United States original jurisdiction, concurrent with the Court of Claims, of any civil action or claim against the United States founded upon this legislation.

EFFECTIVE DATE

Section 15 makes the benefit and contributions provisions of this legislation effective on the first day of the first pay period which begins on or after July 1, 1960, and, by implication, makes the other provisions of the legislation effective upon enactment.

ADMINISTRATIVE REPORTS

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., August 4, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D.C.

MY DEAR MR. CHAIRMAN: Reference is made to your letter of July 8, 1959, requesting the views of the Bureau of the Budget on S. 2162, to provide a

health benefits program for Government employees, presently before your committee.

Since 1954 this administration has advocated, and now continues to advocate, the establishment of a voluntary health insurance program for Federal employees. Specific programs were proposed in 1954, 1955, 1956, and 1957, each proposal being an attempt to formulate a better program. In 1958 the administration gave priority to pay increase legislation and recommended that action on employee health insurance legislation be postponed. It should be noted that during these years Government annual expenditures for Federal employee pay and benefits have been increased by substantial amounts due to increases in pay rates under both the statutory and prevailing wage systems, increases in annuities under employee retirement systems, the liberalization of the premium pay benefits system, the liberalization of the civil service retirement system and the establishment of such new benefits as the allowances for uniforms and the group life insurance and unemployment compensation systems.

Following this administration's basic policy that the Federal employee should be compensated for the services he renders to the Government under a pay and benefit system that is reasonably comparable in structure and level with the compensation provided by progressive private employers, the Bureau of the Budget favors legislation authorizing a Federal employee health insurance program with benefits providing financial protection against the cost of health care reasonably comparable with those benefits provided in private employment. Although the existing Federal employee fringe benefit [*16] system has been reported to be already more liberal

than the typical private business fringe benefit system, it does not include a program of health insurance benefits. Adding these benefits to the existing system will further increase the total value of the Federal employee fringe benefit package. Under these circumstances it is essential that the value added by the new health insurance benefit program be kept in line with private industry health benefits.

The new health insurance benefits should he made available only to employees who earn them by rendering services to the Government under the new program after it becomes effective. Compensation in the form of pay and benefits is paid to employees for services rendered. Former employees who rendered service under a compensation system which did not include these health insurance benefits have already been paid in full for their services in the form of pay and benefits already received or in vested rights to payment of future benefits already earned. Whenever salary or benefits are adjusted an effective date must be selected. It may be unfortunate that some former employees must miss eligibility by narrow margins, and a retroactive approach is often suggested. However, a retroactive approach actually creates an inequity where none would otherwise exist. For while prospective entitlement is firmly linked to services rendered under a compensation agreement, retroactive entitlement is pure gratuity. If any former employee is granted this special gift, then any other former employees who are excluded by the particular retroactive date selected will feel they merit equal consideration. The new health insurance benefits should, therefore, be provided only to employees who render service to the Government after a prospective effective date.

S. 2162, now before your committee, while including several desirable features, falls short of providing an acceptable employee health insurance program in two major respects: the cost to the Government is higher than justifiable in establishing a health insurance benefits program reasonably comparable with existing private business programs, and the organization and administrative system is defective.

The cost-sharing feature of the bill would require the Government to pay one-half of the premiums rather than one-third, as established for the Federal employee group life insurance program in 1954. The first-year cost of the bill to the Government is estimated in the Senate committee report to be $145.3 million, which must be increased by $2.5 million in the first year and $25 million in the fifth year to include the Government share of the cost of annuitant coverage. This amount is substantially higher than the $80 million figure which is actually needed as one-third of the cost, including the cost of annuitant coverage, of a sound program providing a benefit level in line with private industry plans, and providing a sound experience basis for accumulating the facts on which an appropriate Federal employee health benefits program can evolve for the future. It would be prudent for the Government to seek the patterns and level of health benefit protection best suited to the problems of the Federal employee, the benefits that will yield the most effective return for the premium dollar. Experience elsewhere strongly suggests that an effective program will evolve best from a conservative base. Sound development can occur as the genuine needs of the covered employees are clearly defined through experience, and a pattern of effective health care benefits grows up to meet

[*17] these needs. The bill should be modified to clearly provide this sound, conservative beginning.

The organization and administrative provisions of S. 2162 should be modified. The Civil Service Commission will advise you in full detail concerning these modifications. This report will comment only on three organization provisions: the advisory council, the Civil Service Commission reorganization, and the submittal of proposed contracts and regulations.

The functions and membership of the proposed advisory council are not designed to aid sound administration. The council's assigned functions include making investigations of the administration of the program, and receiving reports direct from carriers and employees. Such assignment would confuse the Commission's authority in its relations with carriers, employing agencies, and employees. The Civil Service Commission should be unmistakably responsible for the success of this program. The council's functions should be advisory only. The council's membership should reflect its character as an element of a Federal employee benefit program, and should include appropriate Government officials, ex officio, together with employees, or their representatives, who are contributing and participating in the health insurance system. There is no need to create a statutory organization based on an assumption that the Civil Service Commission may refuse to seek the advice of responsible experts in the health insurance field. Neither is there basis for assuming that the Commission may foster a program which will be deleterious to the public generally, nor that the Commission will fail to give adequate consideration to all parties, including all qualified prospective carriers. The Government's lack of experience in ad-

ministering a health insurance program for its employees and the asserted absence of facts upon which to base decisions does not argue for splitting responsibility in this program between the Civil Service Commission and the advisory council. Rather, it requires placing a special responsibility on the Commission to proceed prudently, to develop factual experience as rapidly as feasible, and to build soundly, and it places a special responsibility on those who contribute to the design of the authorizing statute to provide the clear-cut authority and proper organization that will be so essential. Section 12 should be modified accordingly.

The proposed statutory reorganization of the Civil Service Commission would interfere, to no defined purpose, with the existing statutory power and responsibility of the Chairman of the Civil Service Commission to determine the internal organization of the Commission's business and to designate officers and employees to perform assigned functions. It is especially important in this new program to avoid a rigid organization prescription that could hamper the proper adjustment of administration with experience. Section 13 should be deleted from the bill.

The requirement that the Commission submit proposed contracts and regulations to the Senate and House Committees on Post Office and Civil Service is unnecessary to assure energetic administration by the Commission and is clearly improper if it is intended to provide the committees with a power of prior review of executive action. Subsection (a) of section 16 should be deleted from the bill.

S. 2162, as passed by the Senate, includes several features which are desirable in a program of Federal employee health benefits, but [*18] it seeks to

provide a level of benefits at an unnecessarily high cost, and it provides an unsound system and organization for administration. Unless S. 2162 is modified as to cost and administrative provisions, as above noted, the Bureau of the Budget would not favor enactment of the bill.

Sincerely yours,

MAURICE H. STANS, *Director*.

CIVIL SERVICE COMMISSION,
August 5, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives.

DEAR MR. MURRAY: In response to your letter of July 8, 1959, I am forwarding the Commission's views on the bill S. 2162, to provide a health benefits program for Government employees, as the bill has been amended by the Senate Post Office and Civil Service Committee and reported to the Senate. These views would also apply to H.R. 8210 and H.R. 8211, which are identical to S. 2162.

In the interest of brevity we are not here including a section analysis of S. 2162. The Senate committee's report of July 2, 1959, (No. 468) contains an explanation of the bill by sections. Except as noted hereinafter, the Commission construes the bill as stated in that explanation.

As the central personnel agency of the executive branch, the Commission considers enactment of a health insurance program for Federal employees

highly desirable. Such a program would fill the one remaining major gap in employee fringe benefits and be of inestimable value in attracting and retaining Federal personnel.

We are in complete agreement with the fundamental concepts under lying S. 2162. Very briefly, these would—

(1) Permit employees a free choice among a Government-wide service benefit plan, a Government-wide indemnity benefit plan, a local group practice prepayment plan, and an employee organization plan.

(2) Require contributions from the employee and from the Government.

(3) Make the Commission responsible for the overall administration of the program while sharing the day-to-day operating responsibilities with the employing agencies and the insurance carriers.

(4) Create a central fund into which all receipts would be deposited and out of which all disbursements would be paid.

The soundness of these same concepts (except for the first, which is pertinent only to health insurance) has been solidly established by the efficient operation of the Federal employees' group life insurance program.

The Commission does not, however, altogether favor the manner in which S. 2162 applies these four general principles. We also have serious reservations about several other provisions of the bill. Under the circumstances, we find S. 2162 sufficiently objectionable to compel [*19] us to report unfavorably. If the objectionable features were corrected, we

would find the bill acceptable and a good basis for a successful, enduring health benefits program.

There follows a discussion of what we consider to be the objection-able features of the bill, together with suggestions for rectifying them.

RETROACTIVITY

Regardless of how long before July 1, 1960, S. 2162 were enacted, it would become generally effective no earlier than that date. Section 2(b)(2), however, contains a proviso which would extend the benefits of the bill to certain employees and certain survivors who qualify for annuity between the time the bill is enacted and the time it becomes generally effective.

We appreciate and are not unsympathetic with the purpose of this proviso which is to protect those people who would otherwise be denied the benefits of the bill because, owing to circumstances beyond their control, they are separated before its effective date.

The situation which the proviso in section 2 (b)(2) seeks to cure is not new. It occurs each time beneficial legislation is enacted and on each such occasion it appears that numbers of people have been denied benefits because they were prematurely separated. Depending largely on the value of the benefit, the group which considers itself aggrieved by having been denied the benefits ranges all the way from those who were separated as little as 1 day too early to those who were separated as much as 5 or even 10 years too early.

It is unfortunate that any person has to be denied a benefit because he has been prematurely separated, but we know from long experience that the proviso in section 2(b)(2), although it may slightly

lessen the number of persons who will feel aggrieved, will not appreciably remedy the situation. The proviso in section 2(b)(2) would extend health benefits to certain employees who retire involuntarily or for disability during the interval between the enactment and effective date of the bill and to survivors of certain employees who die during this interval. The number of people whom the proviso will affect will depend on how long this interval may be, but in any event the proviso will not affect the large number of employees who, for example, will voluntarily retire during the interval and later claim they had no knowledge of the fact that, had they waited, they could have qualified. Nor, for another example, will it affect the even larger number of employees who retired (or died) 1 day, 1 week, 1 year before the enactment date.

A line of demarcation must be drawn somewhere. The fairest and firmest place to draw the line is at the date the enacted bill becomes effective. Any retroactivity, unless it were complete, would be discriminatory and would intensify the aggrievement the excluded groups would feel and the representations they would make for having the benefits extended to them. The Commission, therefore, recommends that the following text be deleted from the bill:

(1) Subsection 2(b)(2) on page 23, beginning in line 13 and ending in line 18.

(2) Subsection 3(b)(2) beginning on page 26, line 25, and ending on page 27, line 11.

[*20] BENEFITS AND CONTRIBUTIONS

There are at least two aspects of the bill's benefit-contribution structure which, in the Commission's

view, are so objectionable as to make S. 2162 unsatisfactory. These aspects are as follows:

(1) Government contributions:

At the maximum rates specified in section 7(a), the total contribution required of the Government has been estimated by the Senate committee at $145.3 million annually. We would make two observations concerning this estimate: First, it does not include the sums which the Government would have to contribute annually toward insuring annuitants; second, the administration's frequently stated position is that it cannot at this time acquiesce in spending more than $80 million a year on this program.

(2) Contributions versus benefits:

It can be contended that under section 7(a) contributions of employees and Government may be kept low by setting the rate at a figure less than the maximum authorized amount. But, we are not aware that any carrier has submitted a firm offer to underwrite, at a price less than the maximum contribution rates, the ultrarich benefits which are described in section 5(a)(1) and which are further implied in the Senate committee's report on S. 2162.

In the absence of such firm offer, we have reservations as to whether the implied benefits can be contracted for even at the maximum contribution rates. To the extent that they cannot, or to the extent that Government fiscal policy requires the contribution rates to be set lower than the maximum, the implied ultrarich benefits will have to be curtailed. Any such curtailment in benefits will, like the too-high contribution rates, result in employee disaffection with the program.

We discern other weaknesses in the benefit-contribution structure of S. 2162 but those mentioned above are considered sufficient to justify our recommendation against enactment.

In the absence of a written commitment from a reputable carrier containing detailed specifications of benefits and subscription charges, we believe it wiser not to mislead employees into believing that they will receive ultrarich benefits. It would be infinitely better to delete section 5 of the bill in its entirety and rely on the Commission to negotiate contracts which will provide employees with generally better benefits than they now can get, at a cost to them which, depending on the geographic area, may be less than or about the same as they now pay.

We believe that, to assure enactment of a program, section 7(a) should limit the Government's total contribution to an amount which is acceptable to the administration. And, further, to permit employees who may be so inclined to enroll in plans offering very rich benefits (e.g., some existing group-practice plans) at a subscription charge greater than the maximum contribution rate stipulated in section 7(a), no limit on the employee's contribution rate should be specified. Suggested language to accomplish both these points follows:

[*21] "SEC. 7(a)(1) The Government's contribution to the subscription charge for each enrolled employee or annuitant shall be 33-1/3 % per centum of the subscription charge but may not exceed (i) 95 cents biweekly if he is enrolled for himself alone, or (ii) $2.30 biweekly if he is enrolled for himself and members of his family, or (iii) $1.35 biweekly in the case of a female employee or annuitant who is en-

rolled for herself and members of her family, including a nondependent husband.

"(2) There shall be withheld from the salary of each employee or annuity of each annuitant enrolled in a health benefits plan under this Act so much as is necessary, after deducting the Government's contribution, to pay the subscription charge for his enrollment."

CONTRACTING AUTHORITY

Section 6 authorizes the Commission to negotiate contracts with qualified carriers. It enumerates some of the items to be specified in the contracts but offers no guidance—nor does the Senate committee's report on S. 2162—on what we regard as a critical issue: Should each carrier of a Government-wide plan assume the total risk under his contract or should he be required to share his rights and obligations with other insurers?

For several reasons, but primarily to simplify negotiations with prospective carriers, the Commission considers it highly desirable that the prime carriers' rights and obligations under the two Government-wide plans be shared in much the same manner as the Congress has provided under the Federal Employees' Group Life Insurance Act. While the Commission, in contract negotiations, would probably insist on such sharing even if section 6 were enacted in its present form, it would be preferable to have the Congress express its intent in this regard by including language along the following lines in section 6, perhaps as a new subsection (b):

"(b)(1) The contract for the Government-wide service benefit plan shall require the carrier to allocate its rights and obligations under the contract

among all its affiliates who elect to participate in accordance with an equitable formula to be determined by the carrier and its affiliates and approved by the Commission.

"(2) To be eligible as the carrier for the Government-wide indemnity benefit plan, a company must be licensed to issue group health insurance in all the States and the District of Columbia. The policy for such plan shall require the carrier to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance claims paid in the United States during the latest year for which such information is available, to be determined by the carrier and approved by the Commission."

The Commission assumes, of course, that the national Blue Cross-Blue Shield organization will be the prime carrier for the Government-wide service benefit plan. To eliminate all but a dozen or so of the largest, most responsible insurance companies from consideration as prime carrier of the indemnity benefit plan, and to avoid diversity of citizenship difficulties in the event of a court action by an employee, the suggested language requires the prime carrier to be licensed in all the States and the District of Columbia. All other companies which write group health insurance would, of course, be eligible to acquire their fair share of reinsurance from the prime carrier.

[*22] HEALTH BENEFITS FUND

I am sure your committee is aware that increasing use of hospital and other health services and the continuing rise in the cost of these services has re-

quired many insuring organizations to raise their subscription or premium rates. Some organizations have had to raise their rates several times within the last few years. The current situation in New York City, where the Blue Cross has very recently announced a substantial increase in its rates for the second time in less than 2 years, is characteristic of the trend toward higher insurance costs. Also characteristic is the reported widespread dissatisfaction with the rate increases among subscribers.

Informed opinion is to the effect that steady increases in the cost of providing health services are inevitable. To avoid the necessity of having to increase contribution rates under the Government-sponsored program with unnecessary frequency and, incidentally, to avoid the employee dissatisfaction and the administrative difficulties entailed in each such rate increase, the Commission believes that an adequate contingency reserve should be set aside which could be drawn upon to stave off frequent contribution rate increases. Section 8 of S. 2162 makes no provision for setting aside funds for this purpose other than those derived from "dividends, premium rate credits or other refunds." These refunds (and there is nothing to guarantee that any will be made by the carriers) are completely inadequate for use as a contingency reserve.

The Senate committee, in page 18 of its report on S. 2162, seems to have recognized the need to stabilize contributions by setting aside a portion of contributions as a reserve. It indicates that the reserve shall "not * * * exceed approximately 3 percent of any one year's contributions or [exceed] an accumulative total of approximately 10 percent." However there is no language in section 8 which would au-

thorize retention of any portion of the contributions as a reserve, much less the specific percentages indicated in the Senate committee's report. In view of the explicit authorization in section 8 to set aside a 1 percent reserve for administrative expenses, we question the propriety of setting aside a larger contingency reserve without explicit authorization.

Increases in the cost of health services cannot, of course, be forecast with precision over a long period of years. The Commission feels rather strongly, however, that a contingency reserve should be accumulated which will be adequate to stave off increases in contribution rates for at least the first 5 years of the program's existence and, if possible, longer. To the best of our ability, we have estimated that to do this, it will necessary to set aside moneys up to a maximum of 10 percent of all contributions paid into the fund. Suggested language for amending section 8 to permit the setting aside of an adequate reserve follows:

SEC. 8. (a) There is hereby created a Federal Employees Health Benefits Fund, hereinafter referred to as the "Fund," which is hereby made available without fiscal year limitation for the payment of all subscription charges or premiums under contracts or policies entered into or purchased under section 6. The contributions of employees, annuitants, and the Government toward the subscription charges shall be paid into the Fund. [*23]

"(b) Portions of the subscription charges contributed by employees, annuitants, and the Government shall regularly be set aside as follows: (1) a percentage, not to exceed 1 per centum of all such contributions, determined by the Commission as reasonably adequate to pay the administrative expenses made

available in section 9; (2) for each plan, a percentage, not to exceed 10 per centum of the contributions toward such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. The income derived from any dividends, premium rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future subscription charges, or may be applied to reduce the contributions of employees and the Government to, or to increase the benefits provided by, the plan from which such reserves are derived, as the Commission shall from time to time determine.

"(c) The Secretary of the Treasury is authorized to invest and reinvest any of the moneys in the Fund in interest-bearing obligations of the United States and to sell such obligations of the United States for the purposes of the Fund. The interest on and the proceeds from the sale of any such obligations shall become a part of the Fund."

ADVISORY COUNCIL

The Commission believes that an advisory council can be a valuable adjunct to the health insurance program. Conversely, a council could operate to hamper administration of the program.

In our considered opinion, two features of section 12 will seriously impair efficient operation of the program.

(1) Composition:

The 11-member Council called for by S. 2162 is so large as to inhibit unified and timely action which may be required of it.

Of the members mentioned in clauses (1) through (7) of section 12(a) only the Director of the Bureau of the Budget, because he is concerned with Government fiscal policy, and the three representatives of employee organizations have a continuing intrinsic interest in the program. We do not see that the other members mentioned (the Secretary of Labor, the Surgeon General, the Chief of the Bureau of Medicine and Surgery, a representative of the public, and three representatives of universities) have more than a casual interest in or concern with the program nor what long-range purpose would be served by their permanent membership on the Council. In any event, the services and advice of any or all these persons could be readily obtained when, in a particular situation, it was considered desirable.

We would suggest that section 12 be amended to create a smaller, more efficient Council whose membership would be representative of the vital interests affected by the program. This membership should, in our opinion, consist of the Director of the Bureau of the Budget, the Secretary of the Treasury, because he is charged by S. 2162 with the management of the health benefits fund, the Secretary of Health, Education, and Welfare, because he is officially concerned with public health and health benefits and, finally, to represent employees' interests, two elected officers of employee organizations and two insured employees at large. [*24]

(2) Duties:

Three of the Council's duties prescribed by section 12(b) are sufficiently inappropriate for an *advisory* council to repeat and comment on here:

(a) "to make studies from time to time of the operation and administration of this Act."

This prescribed duty is sheer duplication of what the Commission is required to do by section 11(a)—"[to] make a continuing study of the operation and administration of this Act."

(b) "to receive reports and information with respect [to this Act] from the Commission, carriers and employees and their representatives."

This duty will (1) interpose the Council between the Commission and the carriers and impair the carriers' accountability to the Commission and (2) make the Council a forum for airing employee grievances. Even if S. 2162 did not require it, the Commission would, as a matter of course, furnish reports and information to the Council and otherwise keep it current with developments so that it would have a basis on which to furnish advice and make recommendations.

(c) "to ascertain from time to time the status of the Federal Employees Health Benefits Fund, including the establishment and maintenance of any balances and reserves."

The Commission, as trustee of the fund, would do just this on a continuing basis and its efforts in this regard would automatically be audited by the General Accounting Office.

We cannot help but feel that, especially at the outset of the program, the Advisory Council as constituted by section 12 would have to be in virtually continuous session, would divert the energies and resources of the Commission, and, in general, would impede efficient administration. We urge that section 12 be amended so that it provides for a council

whose function will be to advise and to recommend rather than to monitor the Commission. Language which would do this follows:

"SEC. 12. (a) There is hereby established a Federal Employees Health Benefits Advisory Council which shall consist of the following:

"(1) The Director of the Bureau of the Budget or his representative;

"(2) The Secretary of the Treasury or his representative;

"(3) The Secretary of Health, Education, and Welfare or his representative;

"(4) Four members, to be appointed by the Chairman of the Commission, of whom two shall be elected officers of national employee organizations and two shall be employees enrolled under this Act.

"(b) It shall be the duty of the Advisory Council (1) to consult with and advise the Commission in regard to the administration of this Act, and (2) to make recommendations to the Commission with respect to the amendment of this Act or improvements in its administration.

"(c) Members of the Council who are not otherwise in the employ of the United States shall be entitled while attending meetings of the Advisory Council, including travel time, to receive compensation at [*25] a rate to be fixed by the Commission, but not exceeding $50 per diem, while away from their homes or regular places of business.

"(d) The Advisory Council shall be convened once yearly or oftener on the call of the Chairman of the Commission or on request of any three members of the Advisory Council."

STATUTORY BUREAU OF RETIREMENT AND INSURANCE

The only reasons we know of for the inclusion of section 13 in S. 2162 are the ones advanced in page 19 of the Senate committee's report on the bill. To put it briefly, the Commission does not find these reasons persuasive.

It is quite possible that the Commission may find it advisable to organize a bureau to handle its retirement and insurance functions. This possibility exists whether S. 2162 is enacted or not. The Chairman of the Commission is already empowered by law to reorganize the Commission and if considerations of economy and efficiency should in the future so dictate, he would do this. But his right, among other things, to choose a propitious time for the reorganization, to assign a name to a newly created bureau, to delegate responsibility, and to determine, in accordance with position classification standards, the grade of a bureau director should not be invaded by a statute which is not germane to these matters.

We must strongly urge that section 13 be deleted entirely from S. 2162.

CONTRACTS AND REGULATIONS

The last feature to which the Commission feels obliged to object is the directive in section 16(a) which would require the Commission to transmit by May 1, 1960, to the House and Senate Committees on Post Office and Civil Service, copies of the contracts it proposes to enter into and the regulations it proposes to promulgate.

We cannot perceive nor have we been able to ascertain the purpose of this directive unless it is to assure that the Commission takes timely action to implement the enacted bill. If this is its purpose, its

inclusion in the bill is superfluous since section 16(b) directs that the enacted bill become effective July 1, 1960. If the bill is enacted, we will of course deploy all our resources to have implementation completed by that date. We feel, in this connection, that it is necessary only to call attention to the very prompt action the Commission took in August of 1954 to make the Group Life Insurance Act effective—and this with no effective date specified in the statute.

In addition to being superfluous, section 16(a) would leave the Commission in a quandary in at least two respects.

(1) Prudence would seem to dictate that the Commission, having transmitted copies of the contracts and the regulations, postpone their signing and promulgation while it awaited some formal acknowledgement from both the Senate and House committees that they had objections to or that they approved of the proposed contracts and regulations. The wait could of course result in significant delay but any action, either negative or affirmative, on the part of either committee could be construed as an infringement upon the Executive's powers. [*26]

(2) If between the time copies of the contracts and the regulations were transmitted and the time they were signed and promulgated, changes were made in either or both, the Commission would presumably have to notify the committees of the changes and again await acknowledgements. Such last minute changes could easily occur after May 1, 1960, in which case the Commission could, involuntarily, be in violation of section 16(a).

Viewed in the most favorable light, section 16(a) is superfluous and enigmatic. It should be deleted from the bill.

We are not in this statement of our views suggesting language to perfect a number of relatively minor items in S. 2162 which we think can (and should) be easily improved. Mostly, these improvements would facilitate administration of the program.

I would be glad to have a representative of my office meet with your staff to work out these perfecting changes and, if you wish, to provide such other technical assistance as your committee may want.

The Bureau of the Budget advises that there is no objection to the submission of this statement to your committee.

By direction of the Commission:

Sincerely yours,

ROGER W. JONES, *Chairman.*

OFFICE OF THE POSTMASTER GENERAL,
Washington, D.C., July 28, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to your request for the views of this Department on S. 2162, as amended and reported in the Senate. S. 2162 is a

bill to provide a health benefits program for Government employees.

In previous years the Post Office Department has favored in principle health insurance for Federal employees, provided such insurance could be obtained at a reasonable cost and meets the needs of employees for protection against catastrophic illness. This Department continues to favor such health insurance for Federal employees.

S. 2162 as reported in the U.S. Senate is based on a committee print. The position of the administration on this legislation has been set forth in reports by the Civil Service Commission and by the Bureau of the Budget (pp. 24-28 of S. Rept. 468 to accompany S. 2162). These reports have been brought to the attention of this Department and this Department concurs therein.

It is understood that the U.S. Civil Service Commission and the Bureau of the Budget will file reports with your committee with respect to S. 2162 as reported to the Senate. In the circumstances, this Department has no comments or recommendations to submit with respect to this legislation.

The Bureau of the Budget has advised that there would be no objection to the submission of this report to the committee.

Sincerely yours,

E. O. SESSIONS,
Acting Postmaster General.

[*27] DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,

August 12, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to your request of July 8 for our comments on S. 2162, as passed by the Senate, a bill to provide a health benefits program for Government employees.

Our comments on S. 2162 are also applicable to H.R. 8210 and H.R. 8211, pending before your committee, which appear to be identical with S. 2162.

In view of the detailed explanation of S. 2162 in the report of the Senate Committee on Post Office and Civil Service, we refrain from burdening this report with a summary of the bill.

The pattern of health insurance coverage for Federal employees proposed by this bill is one which this Department considers appropriate and essential, both to meet the health insurance needs of Federal employees and to assure the competition among plans necessary for expansion of voluntary health insurance in the Nation. In this connection, we should like to mention the following basic points:

1. The employee options permit a real choice of coverage by the employee in terms of what he considers best suited to his needs and those of his family, and also provide an opportunity for the development of enrollment procedures which will yield the kind of educational efforts required to promote re-

straint and responsibility in the use of health insurance benefits. Carriers have found such efforts necessary with regard to both the insured and the providers of services.

Employee choices call for reasonable opportunity for changing from one plan to another. If the rules regarding transfer from one plan to another are unduly restrictive, a valuable gage of employee satisfaction and carrier performance can be lost. Since the bill forbids restrictions which would exclude or limit coverage for preexisting diseases or conditions, the main problems in working out reasonable transfer arrangements will be adjustments for premium payments and benefits already availed of during the previous part of the benefit year.

2. The alternative types of plans set forth in the bill permit the development of benefits which could provide full scope of protection for Federal employees. It should be the responsibility of the Commission to see that each of the plans for which it contracts or gives approval offers protection which is substantially equivalent to some desirable level established by the Commission as a yardstick. Important, too, is the opportunity provided under the bill for women employees to gain coverage for their families.

3. The bill accepts the principle of uniform contributions for both active employees and retirees and uniform benefits for these groups. The continuation of protection for retired employees without reduction—with premiums to continue at the same level, and their cost to be shared by the annuitant and the Government in the same proportion, as for active employees—follows a desirable pattern of coverage in health insurance plans generally.

4. The bill permits the setting aside of a portion of the health benefits fund as a special reserve against adverse fluctuations in future charges. A reserve of this type appears wholly appropriate in view [*28] of the nature of health benefits risk and the rising trend in medical care costs.

On such matters as the desirable distribution of premium costs as between the Government and employees, the composition and functions of the Advisory Council, and the proposed establishment of a Bureau of Retirement and Insurance within the Commission, we defer to the views of the Civil Service Commission. We suggest, however, that the Secretary of Health, Education, and Welfare be designated as a member of the Council in place of the Surgeon General of the Public Health Service. It should be noted that our Social Security Administration and the Office of the Special Assistant to the Secretary on Health and Medical Affairs, as well as the Public Health Service, are expert in and concerned with the study and encouragement of voluntary prepayment plans for hospital, medical, and other health services.

We, therefore, recommend enactment of the bill, with the modifications above suggested, and with such further modifications as are indicated by the views of the Civil Service Commission and the Bureau of the Budget, on the Federal share of the costs, on administrative organization, and on the composition and functions of the Advisory Council.

In making this recommendation, we have not overlooked the fact that the bill does not address itself to the problem of health insurance for those who are already retired, a fact that has given us much concern. We consider it essential that legislation for

active employees and future retirees be supplemented in the near future by providing similar protection for those already retired. While we recognize the complexity of the problems involved in providing effective health benefit coverage to those already on annuities, the pressing health insurance needs of retired Federal employees suggest the importance of an early formulation of ways and means to meet their problems.

The Bureau of the Budget advises that it perceives no objection to the submission of this report to your committee.

Sincerely yours,

ARTHUR S. FLEMMING, *Secretary.*

GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE,

Washington, D.C., August 7, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives.

DEAR MR. CHAIRMAN: Reference is made to your request for the views of the Department of Defense on S. 2162, 86th Congress, a bill to provide a health benefits program for Government employees, as reported in the Senate on July 2, 1959.

This bill would provide generally for four basic types of health insurance plans to be made available to Federal employees and annuitants, and members of their families. The bill also covers the level and pattern of benefits to be provided under the various

plans; places certain responsibilities in the Civil Service Commission for overall administration; provides for payroll deductions and matching contributions by the Government; establishes a Federal Employees' [*29] Health Benefits Fund; and creates a Federal Employees Health Benefits Advisory Council and states its duties.

The Department of Defense fully recognizes the importance of group health insurance for its employees. For many years it has encouraged these employees to participate in available group health insurance programs on a voluntary basis, and large numbers are currently participating in such programs. This Department has also consistently supported recommendations for health insurance which have been included in the legislative programs of this administration.

The Department of Defense therefore endorses the basic purposes of S. 2162 and favors the enactment of legislation which will establish a Federal employee health benefits program that will provide sound protection against the high costs of illness at a price which both the employees and the Government can afford. The Department further believes that July 1, 1960, should be the goal for making such program fully effective and removing the unfortunate lag between the Federal Government and private industry in this important area.

Time has not permitted the full and detailed analysis of all the technical provisions of S. 2162 which would be necessary in order to determine whether changes in any of those provisions might produce improvements. However, the Department of Defense considers that this bill does provide the ba-

sis for a sound, well-rounded program of health insurance.

From the standpoint of assuring the most economical and efficient administration of this program, however, the Department of Defense is concerned with those provisions of S. 2162 which establish and prescribe the functions and duties of the Federal Employees Health Benefits Advisory Council.

The wording of section 12 makes this Council much more than an advisory body. It has monitoring and investigative functions, may receive reports and information from various individuals concerned with the program (which to some degree at least give it the character of a grievance committee), and may recommend legislation, presumably with or without concurrence of the Civil Service Commission which is the agency responsible for the program.

All these powers and duties of the Advisory Council will, in the opinion of the Department of Defense, tend to dilute and impair the position of the Civil Service Commission as the administrator of the program, create confusion, and make more complicated the administration of a program which will be complicated enough even under the best of circumstances. It is the belief of the Department of Defense that the Advisory Council should be confined to those functions which the name implies—advising and making recommendations to the Civil Service Commission.

It would also seem unnecessary and undesirable to provide for membership on the Council of representatives of university schools of medicine, hospital administration, and public health. While these are undoubtedly sources from which the Civil Service

Commission would desire to seek information and advice from time to time, this can be done without providing membership and votes on a statutory advisory council. Their interest in and identification with the program established by S. 2162 is not this direct.

S. 2162 provides for an equal sharing by employees and the Government of contributions under the program, which exceeds the maximum [*30] Government contribution previously recommended by the administration. It is estimated that costs to the Department of Defense from legislation of this nature will approximate one-half the costs to the Government, exclusive of costs attributable to coverage of annuitants. Since S. 2162 represents pending legislation, no provision has been made for these costs in the budget of the Department.

The Bureau of the Budget advises that there is no objection to the submission of this report to the Congress.

Sincerely yours,

L. NIEDERLEHNER,
Deputy General Counsel.

COMPTROLLER GENERAL OF THE UNITED STATES,

Washington, July 21, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service, House of Representatives.

DEAR MR. CHAIRMAN: In compliance with your request of July 8, 1959, we offer our comments on S. 2162, as passed by the Senate.

The bill provides generally that there shall be made available to Government employees health benefit plans of the currently popular types, the cost of which will be borne equally by the Government and the employees concerned. The program will generally give Government employees protection equivalent to that enjoyed by commercial and industrial employees.

While the bill involves a matter of policy upon which we offer no recommendation, the following observations are made for such consideration as they may warrant.

Section 2.—Many terms appearing in the bill, some of which are used interchangeably, are not clear. Among these are hospital care, hospital benefits, medical services, ambulatory patients, hospital services, hospital outpatient, other ambulatory patients, diagnostic and treatment services, and professional services. We assume that the Commission will include in its regulations such definitions as may be necessary.

Section 5 (general comments on subsections (a) and (b)).—Subsection (a) provides the benefits to be included in health plans but subsection (b) authorizes the Commission to substitute "alternative" benefits for any and all of the benefits specified in subsection (a). As the section is now written, the alternative benefits could be exclusive of major medical care. We suggest that subsection (b) be revised to insure that the alternative benefits shall include both basic and major medical protection at least equal to that provided under subsection (a). Also, in the event the Commission finds, in the administration of the program, that costs are being adversely affected by excessive or unjustified use of health services, there

may be required some means of protecting the interests of the employees who refrain from such practices. Possibly, as an aid to the Commission, the authority to include deductibles and coinsurance could be made applicable to any benefits offered by the program.

Section 5(a)(1)(A).—While there is general provision for 120 days hospital care, the duration of care provided in cases of tuberculosis and nervous and mental conditions is limited to 30 days. We think [*31] that the supplemental benefits would apply in these cases, immediately after the expiration of 30 days. However, the relationship of this section to the major medical care provided in section 5(a)(1)(E) is not entirely clear. Therefore, we suggest the insertion of an express provision in the bill designating the point at which a tuberculosis or mental patient would be covered by major medical care.

Section 5(a)(1)(B) and 5(a)(1)(C).—The language "to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes" apparently is intended to preclude graduated medical and surgical fees to Federal employees with incomes less than those in the one-quarter group of employees that earn the highest incomes. However, enactment of the language would constitute congressional recognition of the practice of graduated medical and surgical fees to personnel with incomes in the "one-quarter of Federal employees earning the highest incomes." We doubt that congressional recognition should be given to the practice of graduating medical and surgical fees upon the basis of income. Therefore, you may wish to delete the language in the section relating to graduated fees.

Section 5(a)(1)(D).—Benefits for ambulatory patients should be clarified. As the subsection now reads, it is not clear whether it was the intention to require that each of the four plans specified in section 4 include provisions for protection against medical costs for ambulatory patients, or whether care for this class of patients would be restricted to service benefit plans. Further, it is not clear whether the contemplated medical costs would apply to visits of patients to the physician's office when the patient had not been previously hospitalized for the condition subsequently treated at the office. It is likewise not clear whether the section contemplates the payment for house calls made by physicians.

Section 5(a)(1)(E).—The section provides for a sharing of the first $1,500 of expenses and that the carrier shall pay all costs in excess of $1,500 subject to maximums determined by the Commission. Your committee may wish to consider the desirability of prescribing in the law itself maximum and minimum amounts that would be payable in addition to the first $1,500. This point would be of particular significance if the cost of benefits provided under a plan should increase to a point where it may be necessary for the Commission to reduce certain of such benefits to stay within the limit of available funds.

Also, we suggest the addition of the following language to be inserted after the word "subparagraph" appearing on line 10, page 31, "shall include any and all diseases but".

Section 5(a)(1)(F).—Apparently under this paragraph no supplemental benefits would be provided for any normal delivery even though complications may develop prior to the patients' complete recovery.

Section 5(a)(2).—We do not have the details of the benefits which may be offered under the indemnity plan. We recommend, however, that the bill require or, at least, that the committee report specify that the value of benefits under the indemnity plan generally coincide with the value of the services furnished under the service plan, including coverage of all diseases.

Section 6.—The bill specifies that the Commission shall approve two nationwide plans, one of the service type and one of the indemnity type, and authorizes the Commission to enter into nationwide con-[*32]tracts for benefits provided by the two plans. Under such conditions the question arises as to what recognition is to be given to the variations in hospital room rates, medical services, and surgical fees between various localities. Since schedules of benefits will be applicable nationwide, there will be a tendency for those hospitals and surgeons heretofore charging less than the stated maximum to increase their rates and fees until they reach the maximum levels specified. This result would add to the cost of the program for both the employee and the Government. In our opinion the bill should specify that the nationwide contracts contain language assigning to the carrier responsibility for maintaining costs at prevailing local levels. We suggest language similar to the following be added to section 6(b) "Any nationwide prime contract shall include a requirement that the carrier's subcontracts or other arrangements with corporations, associations, groups, doctors, hospitals, and other providers of health services shall be stated at cost levels no higher than the (1) charges to the general public, or (2) schedules of health benefit costs in local health benefit plans."

We suggest that this section be amended to authorize the Commission to require reinsurance if it deems such action is necessary to protect the interests of the Government. Similar reinsurance is required under the Government Employees Life Insurance Act.

Section 7(b).—This section covers employees who are on leave without pay and would vest in the Commission discretion to regulate the coverage to be granted. Presumably, this discretion is necessary to enable consideration of the circumstances involved in individual cases concerning authorized or unauthorized leave without pay. Consideration might be given to providing the Commission guidelines for its administration of this section in your committee's report.

Section 8.—We recommend a technical revision in this section. After the word "Fund" on page 36, line 14, insert the language "which shall be administered by the Commission and". Also, on page 37, after the word "Fund" appearing on line 15, insert the language "when directed by the Commission."

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

COMPTROLLER GENERAL OF THE UNITED STATES,

Washington, August 17, 1959.

B-119033.

Hon. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives.

DEAR MR. CHAIRMAN: As a result of a number of conferences between members of our respective staffs we have been requested to report on the version of the bill S. 2162 presently under consideration by your committee. We are pleased to offer the following comments on the bill as presently revised by the committee.

Health benefit plans (sec. 4, p. 30)

Section 4 of the bill provides that there shall be one Government-wide service benefit plan and one Government-wide indemnity plan. **[*33]** Testimony before the committee has disclosed clearly that in order to provide a health plan within the reach of the employees in the lower grades, and for basic fiscal policy reasons, a benefits plan with relatively low or "thin" benefits will be acquired. Under the requirement that only one service and one indemnity plan may be operative, such plans may and probably will not provide a benefit level desired by the majority of employees in the middle or upper grades, nor will the new uniform medium or low benefit plan compare favorably with broader coverage now carried by many employees. We suggest that the committee consider revising this section of the bill to require the providing of at least two levels of benefits for each of the two primary plans created by sections 4(1) and 4(2). Two levels of benefits would provide a more flexible choice to the employees, enabling them to consider local cost conditions, and would also recognize the employees' ability to pay. In our opinion the option for two levels of benefits under each major plan could be included within a single contract with the respective carriers. While the cost of administration will necessarily be increased by additional op-

tions, we believe that the matter can be worked out by the Commission to assure a minimum of increased costs. The following language, or some modification thereof, added to sections 4(1) and 4(2) would provide a basis for the Commission to develop two levels of benefits and two levels of cost under each of the two nationwide plans:

"*Provided*, That any such plan shall include two levels of benefits and two related levels of subscription or premium charges."

Contracting authority (sec. 6, p. 38)

The committee has received testimony that experience under many health plans indicates they are subject to costly abuses. Published material indicates a rather significant overutilization of hospital services when the individuals are insured for hospital services only. Some published data has indicated that unnecessary hospitalization under insurance or service plans runs as high as 20 percent.

If abuses occur, then costs borne by the employee and the Government will be correspondingly higher. Conversely, if the unnecessary services and the related costs are curtailed, then more funds will be available to provide the necessary benefits. The unnecessary use of hospital room and board in order to obtain other needed services not available unless the patient is hospitalized, is an example of abuse. The insurance industry and the large employers have devised contract provisions designed to curtail nonessential utilization of health services, and it would seem that where appropriate the Government should apply similar and other effective provisions. Coverage of all medical services, coupled with coinsurance and deductibles are among the corrective devices

used. The committee may wish to state in the bill an expression of policy for the guidance of the Commission in framing contracts to provide to the extent possible for the curtailment of abuses of the Government health plans by the users of the services or benefits. This could be accomplished by adding a provision to section 6 of the bill, reading substantially as follows:

"Regulations of the Commission shall require that all plans or contracts include benefits, in specified categories of health services, and at such levels, as the Commission determines necessary to restrict excessive utilization or abuse of any service. The standards shall [*34] include such other provisions, including coinsurance and deductible provisions, determined by the Commission to be necessary to prevent abuses of the program."

Contributions (sec. 7(a)(1), p. 36)

We wish to point out that section 7(a)(1) as written, permits the Commission full discretion regarding the level of benefits that may be acquired. The benefits may be set very low—substantially below the amounts stated in subparagraphs (i) and (ii)—and in such cases the Government would pay 50 percent of the costs. If the benefits acquired are liberal and the costs higher, then the Government may pay less than 50 percent of the costs.

Also, we note that the minimums and maximums between which the Commission must set the "prescribed" amounts are apparently intended to be applicable uniformly to all plans. However, it is possible to interpret the language of this section as authorizing variable "prescribed" amounts, within the three categories of minimum and maximum limits

stated in the bill. We believe this would be inequitable to employees who were members of the plans assigned low "prescribed" amounts. We suggest the following change on line 7, page 36:

"The amounts so prescribed, which shall be uniform for all plans, shall not—."

Subscription charges and premiums

The bill contains numerous references to "subscription charges" and "premiums." However, the manner in which the terms are used indicates that in some instances these terms refer to the combined amount represented by payroll deductions from employees and the Government's transfer to the fund, and in other instances one or both of the terms refer to the payment from the fund to the carriers. These amounts paid into the fund will not necessarily be the same as the amounts paid out to carriers, as the bill is now written. The difference in the amounts is due to allowances for expenses and credits to the reserve. It is suggested that the use of these terms throughout the bill be reviewed and their specific use clarified by editorial change.

We will be pleased to provide any further information or assistance in connection with this proposed legislation that the committee desires.

Sincerely yours,

FRANK H. WEITZEL,
Assistant Comptroller General of the United States.

[*1]

94TH CONGRESS 2d Session | HOUSE OF REPRESENTATIVES | REPORT No. 94-1211

PREEMPTION OF STATE LAWS INCONSISTENT WITH FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

JUNE 2, 1976.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. WHITE, from the Committee on Post Office and Civil Service,
submitted the following

REPORT

[To accompany H.R. 12114]

The Committee on Post Office and Civil Service, to whom was referred the bill (H.R. 12114) to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employees health benefits and coverage provided pursuant to contracts made wider such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

On the first page, beginning on line 8, strike out "payment, nature, or extent of benefits or coverage"

and insert in lieu thereof "nature or extent of coverage or benefits (including payments with respect to benefits)."

EXPLANATION OF AMENDMENT

The committee amendment merely improves the grammatical structure of the bill.

PURPOSE

The sole purpose of H.R. 12114 is to establish uniformity in benefits and coverage under the Federal Employees' Health Benefits Program by providing that the provisions of any contract under such program shall supercede and preempt any State or local law or regulation that is inconsistent with such contractual provisions.

COMMITTEE ACTION

H.R. 12114, as amended, was ordered reported by voice vote of the Committee on Post Office and Civil Service on May 6, 1976. Public hearings on H.R. 12114 were conducted by the Subcommittee on Re-[*2]tirement and Employee Benefits on March 23 and 25, 1976 (Hearing No. 94–69). On April 28, 1976, the Subcommittee, by unanimous voice vote, approved H.R. 12114, with a technical amendment, for full committee consideration.

BACKGROUND

The Federal Employees' Health Benefits (FEHB) Program, established by the Federal Employees' Health Benefits Act of 1959, now codified in chapter 80 of title 5, United States Code, provides health insurance coverage for about three million Federal employees and annuitants and six million dependents. The contracts negotiated between the Civil Service Commission and the various FEHB carriers

are required to provide the same benefits for the same premium for all enrollees in a particular plan. The contracts specify the benefits to be provided by the various plans and the premium cost which is shared by the Government and the enrollees.

The total cost of the program in fiscal year 1974 was approximately $1.6 billion of which amount the Government contributed approximately $960 million. The total cost of the program for fiscal year 1976 will be about $2 billion.

On February 20, 1975, the Honorable Richard C. White, Chairman of the Subcommittee on Retirement and Employee Benefits, requested the Comptroller General of the United States to furnish a report identifying those State health insurance requirements which conflict with contracts negotiated between the FEHB carriers and the Civil Service Commission. On October 17, 1975, the Comptroller General submitted his report (B–164562) which discusses the various State conflicts, the carriers' methods of dealing with these conflicts, and the position of the Civil Service Commission and certain carriers regarding the applicability of State requirements to the FEHB contracts. In addition, the Comptroller General found that—

(1) Some doubt and confusion exists among the carriers and the States regarding the applicability of State requirements to FEHB contracts, and

(2) The States are becoming increasingly active in establishing and enforcing health insurance requirements.

As a result of his findings, the Comptroller General recommended that the Subcommittee consider

legislation to clarify the applicability of State insurance requirements to FEHB contracts. Pursuant to the Comptroller General's suggestion, Chairman White introduced H.R. 12114.

STATEMENT

The Subcommittee's hearings on H.R. 12114 confirmed the finding of the Comptroller General that there exists much doubt and confusion on the part of the carriers and the States regarding the applicability of various State health insurance requirements to the Federal Employees' Health Benefits contracts. As a result, decisions regarding health benefits or services required by States, but not covered under the Federal Employees Health Benefits Program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Some States have established health insurance requirements that conflict with the provisions of the FEHB contracts, such as requiring recognition of certain practitioners not covered by Federal Employees' [*3] Health Benefits plans. Many States have not attempted to enforce their requirements that conflict with the FEHB plans. In other States, the carriers have been successful in convincing the States that the Federal employees' plans are exempt from State requirements. Other States have enforced their requirements but have not done so uniformly for all carriers in the Federal program.

For example, the Indemnity Benefit Plan (Aetna) pays for chiropractic services in Nevada, as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractic services only in New York and Montana where State laws require coverage for such

services. The Services Benefit Plan has been required to pay for these services only in Maryland and Oklahoma. Even in the States that have enforced conflicting requirements, few Federal enrollees are aware of the States' requirements, and, as a result, most enrollees do not attempt to obtain reimbursement for chiropractic services.

Some plans have requested the assistance of the Civil Service Commission in obtaining exemptions from the State requirements, but the Commission has consistently taken the position that the States now have the authority to regulate the plans.

The cost of revising the carriers' contracts with the Civil Service Commission to include all benefits required by States is difficult to estimate because of such unknown factors as the potential utilization of these benefits. However, representatives of Aetna Life and Casualty (the Indemnity Benefit Plan) believe that they would have to increase their premiums by as much as five percent to cover such benefits.

Because the States are becoming more active in establishing and enforcing health insurance requirements which conflict with provisions of FEHB contracts, these conflicting requirements can be expected to result in:

Increased premium costs to both the Government and enrollees and

A lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

In view of the doubt and confusion that exists among the health benefit carriers and many States, the increased activity of the States in establishing and enforcing health insurance requirements, and the necessity and desirability of providing uniform coverage for all enrollees in each option of each plan, the committee strongly recommends enactment of H.R. 12114.

The Administration supports the enactment of H.R. 12114. In that regard, it is the view of the Administration that the Federal Employees' Health Benefits Program—a program established by an Act of Congress—should not be subject to alteration or regulation by State legislatures or State insurance boards. The committee fully concurs in this view.

ANALYSIS OF H.R. 12114

H.R. 12114 amends section 8902 of title 5, United States Code, relating to contracts for Federal employee health benefits plans, by adding a new subsection (1) at the end thereof. The new subsection provides that the provisions of any health benefits contract under chapter 89 [*4] of title 5 which relate to the nature or extent of coverage or benefits, including payments with respect to benefits, shall supersede and preempt any State or local law, or any regulation issued under such law, relating to health insurance or plans, to the extent that such law or regulation is inconsistent with the provisions of the Federal employees' health benefits contract. The effect of this amendment is to preempt the application of State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage when such laws or regulations conflict

with the provisions of contracts under the Federal Employees Health Benefits Program. However, the amendment is not intended to apply to State or local laws relating to the taxation of health insurance carriers or to the maintenance of special reserves.

COST

The enactment of H.R. 12114 will not result in any additional cost to the Government. This legislation could result in a savings to the Government since, in the absence of this legislation, the future application of conflicting State and local health insurance laws would result in an increase in Federal employees' health insurance premiums of which the Government now pays approximately 60 percent.

NEW BUDGET AUTHORITY AND NEW SPENDING AUTHORITY

This bill does not provide authority to enter into new obligations which will result in immediate or future outlays involving Government funds, and therefore, the requirements of section 308(a) of the Congressional Budget Act of 1974, relating to a statement on new budget authority, are not applicable to this bill.

H.R. 12114 does not provide "new spending authority" as that term is defined under section 401 of the Congressional Budget Act of 1974, and therefore the requirements of section 401(b)(2) of that Act, relating to new spending authority which may result in new budget authority exceeding the appropriate allocation, are not for application to this legislation as stated above, this bill will not result in any cost to the Government.

OVERSIGHT

Under the rules of the Committee on Post Office and Civil Service, the Subcommittee on Retirement and Employee Benefits is vested with legislative and oversight jurisdiction over the subject matter of this legislation. As a result of the hearings on this legislation, the Subcommittee concluded that there was ample justification for amending the law in the manner provided under H.R. 12114.

The committee received no report of oversight findings or recommendations from the Committee on Government Operations pursuant to clause 2(b)(2) of House rule X.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4) of House rule XI, the Committee has concluded that the enactment of H.R. 12114 will have no inflationary impact on the national economy.

[*5] AGENCY VIEWS

There are set forth below the reports of the United States Civil Service Commission and the Office of Management and Budget on H.R. 12114.

U.S. CIVIL SERVICE COMMISSION,
Washington, D.C., March 22, 1976.

Hon. DAVID N. HENDERSON,
Chairman, Committee on Post Office and Civil Service, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in further reply to your request for the Commission's views on H.R. 12114, a bill "To amend chapter 89 of title 5, United States Code, to establish uniformity in Fed-

eral employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts."

H.R. 12114 would, in effect, exempt the Federal Employees Health Benefits (FEHB) Program from any State or local law or regulation to the extent that such law or regulation conflicted with the provisions of the FEHB contract. This would statutorily establish uniformity of benefits and coverage under the FEHB Program and the Commission strongly urges favorable consideration of the bill.

The Federal Employees Health Benefits Act, now codified in chapter 89 of title 5, United States Code, gives the Commission sole authority to negotiate contracts with participating carriers, and to prescribe regulations to implement its provisions. However, the FEHB law contains no clear statement which would authorize the Commission to prescribe regulations restricting the application of state laws in relation to the Commission's health benefits contracts.

All states regulate the insurance business in various (and varying) ways. Apparently, in the early years of the FEHB Program, FEHB plans were either in compliance with these laws, or the laws excluded FEHB plans, or the states elected not to enforce laws that conflicted with FEHB plans. Whatever the reason, state laws offered few if any problems for our program.

In the past several years, however, more and more states have legislated the kinds of benefits and medical practitioners that carriers doing business in

these states must cover. This presents a very real danger to the uniformity of benefits under the FEHB program. For example, the Aetna Life and Casualty (carrier of the Government-wide Indemnity Benefit Plan) is currently being compelled to pay for the services of chiropractors in several states, even though our contract with Aetna does not recognize these practitioners as covered providers. If they refused to comply they would lose their license to provide health insurance in those states and would no longer be eligible as the Indemnity Benefit carrier under the FEHB Program, since the law (5 U.S.C. 8902(b)) requires them to be licensed in all 50 states and the District of Columbia.

Aetna contended that such state laws are preempted by the FEHB Act, and asked the Commission's Office of General Counsel to concur in their position that the McCarran-Ferguson Act establishes the preemption inasmuch as McCarran-Ferguson recognizes the authority of [*6] the states to retain the power to regulate the business of insurance, except where an Act of Congress (i.e., 5 U.S.C. chapter 89) "specifically relates to the business of insurance." However, the General Counsel's response to Aetna noted that the FEHB Act, although it authorizes the Commission to enter into contracts with insurers, does not provide that the Commission actually conducts insurance business. They therefore found no legal merit in Aetna's position but, instead, found that the states could indeed regulate our plans.

As a result, numerous states, including some which have previously acknowledged that their laws do not apply to our contracts, are more aggressively pursuing the preemption problem. States are enact-

ing insurance laws affecting not only specific types of care, extent of benefits and specific types of providers, but also family members covered, age limits for family members, extension of coverage, and conversion contracts. Additionally, numerous state laws are being made extraterritorial to overcome our carriers' argument that our contracts are made in the District of Columbia and not in the state.

One of the most beneficial features of our FEHB plans is the requirement that they provide the same uniform benefits for the same premium for all enrollees in a plan. This can no longer be enforced if carriers are compelled to pay extra-contractual benefits in some of the states in compliance with state or local laws.

Presumably, the states have (and now seem to want to exercise) the authority to determine what benefits will or will not be paid, who is a covered medical practitioner, and who is an eligible family member. It is imperative that some action be taken to deal with what is becoming a serious problem. If nothing is done, it is logical to assume that the states rather than the Federal Government will become the final arbiters of what is and is not covered by the FEHB Program.

The Commission has studied various possible solutions to this problem. It is our belief that legislation such as H.R. 12114 preempting the FEHB Program from state or local law offers the only permanent solution. Additionally this appears to be the only solution which would not compromise the principle of uniform benefits for all enrollees in a plan, and which would not result in additional cost to the Government.

For these reasons the Commission strongly urges enactment of H.R. 12114.

The Office of Management and Budget advises that from the standpoint of the Administration's program there is no objection to the submission of this report.

By direction of the Commission:

Sincerely yours,

GEORGIANA SHELDON,
Acting Chairman.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., March 23, 1976.

Hon. DAVID N. HENDERSON,
Chairman, Committee on Post Office and Civil Service, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to the Committee's request for the views of this Office on H.R. 12114, "To amend chapter 89 of title 5, United States Code, to establish uniformity in Federal em-[*7]ployee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts."

The purpose of this bill is to exempt the Federal Employees Health Benefits (FEHB) program from State or local laws or regulations to the extent they conflict with the provisions of an FEHB contract, in

order to ensure that benefits and coverage under the program will be uniform.

In its report and testimony, the Civil Service Commission states a number of reasons for supporting enactment of this bill.

We concur in the views expressed by the Civil Service Commission and, accordingly, recommend enactment of H.R. 12114.

Sincerely,

JAMES M. FREY,
Assistant Director for Legislative Reference.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 8902 OF TITLE 5, UNITED STATES CODE

§ 8902. Contracting authority

(a) The Civil Service Commission may contract with qualified carriers offering plans described by section 8903 of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company

must be licensed to issue group health insurance in all the States and the District of Columbia

(c) A contract for a plan described by section 8093(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Commission; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Commission.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Commission considers necessary or desirable.

(e) The Commission may prescribe reasonable minimum standards for health benefits plans described by section 8903 of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned [*8] without regard to subchapter II of chapter 5 and chapter 7 of this title. The Commission may terminate the contract of a carrier effective at the end of the contract term, if the Commission finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of this first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee or annuitant whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee or annuitant who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Commission, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Commission, is consistent with the general practice of

carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter, shall require the carrier to agree to pay for or provide a health service or supply an individual case if the Commission finds that the employee, annuitant, or family member is entitled thereto under the terms of the contract.

(k) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist or optometrist, licensed or certified as such under Federal or State law, as applicable, an employee, annuitant, or family member covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist or optometrist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed. The provisions of this subsection shall not apply to group practice prepayment plans.

(l) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

[*1]

95TH CONGRESS *1st Session*

HOUSE OF REPRESENTATIVES

REPORT No. 95-282

PREEMPTION OF STATE LAWS INCONSISTENT WITH FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

MAY 10, 1077.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mrs. SPELLMAN, from the Committee on Post Office and Civil Service,
submitted the following

REPORT

[To accompany H.R. 2931]

The Committee on Post Office and Civil Service, to whom was referred the bill (H.R. 2931) to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment (stated in terms of the page and line number of the introduced bill) is as follows:

Page 1, line 7, strike out "(l)" and insert "(m)".

EXPLANATION OF AMENDMENT

The committee amendment merely corrects an erroneous subsection designation.

PURPOSE

The sole purpose of H.R. 2931 is to establish uniformity in benefits and coverage under the Federal employees' health benefits program by providing that the provisions of any contract under such program shall supersede and preempt any State or local law or regulation that is inconsistent with such contractual provisions.

COMMITTEE ACTION

H.R. 2931 is identical to the bill H.R. 12114 which passed the House on the Consent Calendar during the 94th Congress. In view of the fact [*2] that hearings were held on this proposal during the 94th Congress (see Hearing No. 94-69), no hearings were held on H.R. 2931 this year.

On March 8, 1977, the Subcommittee on Compensation and Employee Benefits unanimously approved H.R. 2931, and on April 27, 1977, the full committee ordered the bill reported by a record vote of 13 to 0.

The administration supports the enactment of H.R. 2931.

BACKGROUND

The Federal employees' health benefits (FEHB) program, established by the Federal Employees' Health Benefits Act of 1959, now codified in chapter 89 of title 5, United States Code, provides health insurance coverage for about 3 million Federal employees and annuitants and 6 million dependents. The

contracts negotiated between the Civil Service Commission and the various FEHB carriers are required to provide the same benefits for the same premium for all enrollees in a particular plan. The contracts specify the benefits to be provided by the various plans and the premium cost which is shared by the Government and the enrollees.

The total cost of the program in fiscal year 1976 was approximately $2.2 billion of which amount the Government contributed approximately $1.4 billion. The total cost of the program for fiscal year 1977 will be about $2.5 billion.

On February 20, 1975, the Chairman of the former Subcommittee on Retirement and Employee Benefits requested the Comptroller-General of the United States to furnish a report identifying those State health insurance requirements which conflict with contracts negotiated between the FEHB carriers and the Civil Service Commission. On October 17, 1975, the Comptroller General submitted his report (B-164562) which discusses the various State conflicts, the carriers' methods of dealing with these conflicts, and the position of the Civil Service Commission and certain carriers regarding the applicability of State requirements to the FEHB contracts. In addition, the Comptroller General found that—

(1) Some doubt and confusion exists among the carriers and the States regarding the applicability of State requirements to FEHB contracts, and

(2) The States are becoming increasingly active in establishing and enforcing health insurance requirements.

As a result of his findings, the Comptroller General recommended that the subcommittee consider legislation to clarify the applicability of State insurance requirements to FEHB contracts.

STATEMENT

The hearings held during the 94th Congress (Hearing No. 94-69) confirmed the finding of the Comptroller General that there exists much doubt and confusion on the part of the carriers and the States regarding the applicability of various State health insurance require-[*3]ments to the Federal employees' health benefits contracts. As a result, decisions regarding health benefits or services required by States, but not covered under the Federal employee's health benefits program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Some States have established health insurance requirements that conflict with the provisions of the FEHB contracts, such as requiring recognition of certain practitioners not covered by Federal employee's health benefits plans. Many States have not attempted to enforce their requirements that conflict with the FEHB plans. In other States, the carriers have been successful in convincing the States that the Federal employees' plans are exempt from State requirements. Other States have enforced their requirements but have not done so uniformly for all carriers in the Federal program.

For example, the Indemnity Benefit Plan (Aetna) pays for chiropractic services in Nevada, as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractic services only in New York and Montana where State law requires coverage for such

services. The Services Benefit Plan has been required to pay for these services only in Maryland and Oklahoma. Even in the States that have enforced conflicting requirements, few Federal enrollees are aware of the States' requirements, and, as a result, most enrollees do not attempt to obtain reimbursement for chiropratic services.

As a result of this situation, officials of the Civil Service Commission asked the General Counsel of the Commission to review the law and furnish legal opinion on the question of the dominance of the Federal Employees' Health Benefits law over State and local laws. The General Counsel's conclusion was that, based on the supremacy clause of the Constitution, the Federal Employees' Health Benefits law preempts State-and local laws in this area. While the Commission has adopted the views of its General Counsel, the Commission has advised the committee as follows:

> The Commission adopted the views of the General Counsel that the Federal Employees Health Benefits Act preempts state laws in this area. The Commission realizes that enforcement of this preemption policy will almost inevitably lead to time consuming and costly litigation with the states until its position is finally upheld by the courts. We do not view this as necessary or desirable. H.R. 2931 while it has more limited applicability does provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in the plan and enables the Commission, acting on behalf of the Government, to administer the Federal Employees Health

Benefits Act in a reasonable and efficient manner. Furthermore, enactment of H.R. 2931 should result in a reduction in cost to the Federal Government and the employees.

For these reasons the Commission strongly urges enactment at an early date of H.R. 2931.

[*4] The cost of revising the carriers' contracts with the Civil Service Commission to include all benefits required by States is difficult to estimate because of unknown factors such as the potential utilization of these benefits. However, representatives of Aetna Life and Casualty (the Indemnity Benefit Plan) believe that they would have to increase their premiums by as much as 5 percent to cover such benefits. Further, the Civil Service Commission estimated, in testimony during the 94th Congress, that approximately $125 million is being expended annually for benefits not covered under the FEHB contracts due to the various conflicting State and local laws.

It is clear that States are becoming more active in establishing and enforcing health insurance requirements which conflict with provisions of the FEHB contracts. These conflicting requirements can be expected to result in:

Increased premium costs to both the Government and enrollees, and

A lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

In view of the doubt and confusion that exists among the health benefits carriers and many States, the increased activity of the States in establishing and enforcing health insurance requirements, and the necessity and desirability of providing uiform coverage for all enrollees in each option of each plan, the committee strongly recommends enactment of H.R. 2931.

The administration supports the enactment of H.R. 2931. In that regard, it is the view of the administration that the Federal employees' health benefits program—a program established by an Act of Congress—should not be subject to alteration or regulation by State legislatures or State insurance boards. The committee fully -concurs in this view.

ANALYSIS OF H.R. 2931

H.R. 2931 amends section 8902 of title 5, United States Code, relating to contracts for Federal employee health benefits plans, by adding a new subsection (m) at the end thereof. The new subsection provides that the provisions of any health benefits contract under chapter 89 of title 5 which relate to the nature or extent of coverage or benefits, including payments with respect to benefits, shall supersede and preempt any State or local law, or any regulation issued under such law, relating to health insurance or plans, to the extent that such law or regulation is consistent with the provisions of the Federal employees' health benefits contract. The effect of this amendment is to preempt the application of State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage when such laws or regulations [*5] conflict

with the provisions of contracts under the Federal employees' health benefits program. However, the amendment is not intended to apply to State or local laws relating to the taxation of health insurance carriers or to the maintenance of special reserves.

COST

The enactment of H.R. 2931 will not result in any additional cost to the Government. This legislation could result in a savings to the Government since, in the absence of this legislation, the future application of conflicting State and local health insurance laws would result in an increase in Federal employees' health insurance premiums of which the Government now pays approximately 60 percent.

NEW BUDGET AUTHORITY AND NEW SPENDING AUTHORITY

This bill does not provide authority to enter into new obligations which will result in immediate or future outlays involving Government funds, and therefore the requirements of section 308(a) of the Congressional Budget Act of 1974, relating to a statement on new budget authority, are not applicable to this bill.

H.R. 2931 does not provide "new spending authority" as that term is defined under section 401 of the Congressional Budget Act of 1974, and, therefore, the requirements of section 401(b) (2) of that act, relating to new spending authority which may result in new budget authority exceeding the appropriate allocation, are not for application to this legislation.

OVERSIGHT

Under the rules of the Committee on Post Office and Civil Service, the Subcommittee on Compensation and Employee Benefits is vested with legislative and oversight jurisdiction over the subject matter of this legislation. As a result of the hearings on this legislation conducted during the 94th Congress, the subcommittee concluded that there was ample justification for amending the law in the manner provided Under H.R. 2931.

The committee received no report of oversight findings or recommendations from the Committee on Government Operations pursuant to clause 4 (c) (2) of House rule X.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1) (4) of House rule XI, the committee has concluded that the enactment of H.R. 2931 will have no inflationary impact on the national economy.

AGENCY VIEWS

There is set forth below the report of the United States Civil Service Commission recommending enactment of H.R. 2931. **[*6]**

UNITED STATES CIVIL SERVICE COMMISSION,
Washington, D.C., May 9, 1977.

Hon. ROBERT N. C. NIX,
Chairman, Committee on Post Office and Civil Service, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in further reply to your request for the Commission's views on

H.R. 2931, a bill "to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts."

H.R. 2931 would exempt the Federal employees health benefits program from any State or local law or regulation to the extent that such law or regulation conflicted with the provisions of the Federal Employees Health Benefits Act, regulations issued or contracts negotiated thereunder insofar as they pertain to benefits and coverage. It would not, as we read it, exempt the insurance carriers under the Federal employees health benefits program from the payment of State premium taxes, State requirements for statutory reserves; or other such regulations pertaining to the regulation of insurance within the State. It is a form of limited preemption.

The bill would statutorily establish uniformity of benefits and coverage under the Federal employees health benefits program as well as solve the other problems encountered in recent years in the administration of the program. The Commission strongly urges favorable consideration of the bill.

All States regulate the health insurance business in various and varying ways. During the early years of the Federal employees health benefits program, our plans and contracts were either in compliance with these laws and regulations or the States elected not to enforce laws that conflicted with our plans. Whatever the reason, State laws offered few if any problems for our program. Over the past several years, however, more and more States have legislat-

ed the kinds of benefits and medical practitioners that carriers doing business in these States must cover. These laws in effect presented serious problems from the standpoint of the uniformity of benefits under the program. It also placed carriers in serious jeopardy of loss of their license in a State unless they were to approve pay for a benefit not provided under our contract but required by State law. The problem was complicated by the fact that if the Indemnity Benefit Plan carrier, Aetna, lost their license to provide health insurance in those States or in any State they would no longer be eligible as a carrier under the Federal Employees Health Benefits law since the law (5 U.S.C. 8902 (b)) requires them to be licensed in all 50 States and the District of Columbia. We would have no Governmentwide Indemnity Benefit Plan. In addition to legislation and regulations applying to the kinds of benefits and medical practitioners that must be recognized, many States went further in requiring not only specific types of care but the extent of benefits, family members to be covered, the age limits for family members, extension of coverage, the format and the type of informational material that must be furnished, including in some instances the type of [*7] language to be used, extension of coverage and the type of conversion contracts that must be offered. The problem was further compounded by numerous State laws being made extraterritorial. The effect of these conflicting State laws had on our program was that if we were to continue or our carriers were to continue to be subject to State law the benefits provided to Federal employees could not be uniform throughout the country and were largely determined on the basis of what State the employee either resided in or worked in. In terms of contracting with the carrier, it was

reaching a point where unless we were to negotiate contracts that included all the requirements of the various State laws and applied them nationwide, we would continue to place our carriers in a position where they would not be in compliance with some State law. In addition, many of the State laws were in conflict with one another. It appeared that under these circumstances the only solution to the problem would lie in negotiating contracts for Federal employees in each State and issuing separate brochures to meet individual State requirements.

Confronted with this situation the General Counsel of the Commission was asked to review the law and furnish a legal opinion on the question of the dominance over State and local laws of the Federal Employees Health Benefits Act. The General Counsel's conclusion was that "the supremacy clause creates an immunity from State interference of Federal operations. The principle underlying the need for national uniformity in the administration of Federal functions operate to supersede conflicts arising from State laws and apply with equal regard to the Commission's administration of the Federal Employees Health Benefits Act. The McCarran-Ferguson Act by its terms and the interpretation of the courts in no way diminishes the supremacy 431 the Federal Employees Health Benefits Act over State laws. If the Commission is to have a free hand it needs to administer the Federal Employees Health Benefits Act, no other conclusion can be reached."

The Commission adopted the views of the General Counsel that the Federal Employees Health Benefits Act preempts State laws in this area. The Commission realizes that enforcement of this preemption policy will almost inevitably lead to time

consuming and costly litigation with the States until its position is finally upheld by the courts. We do not view this as necessary or desirable. H.R. 2931 while it has more limited applicability does provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in the plan and enables the Commission, acting on behalf of the Government, to administer the Federal Employees Health Benefits Act in a reasonable and efficient manner. Furthermore, enactment of H.R. 2931 should result in a reduction in cost to the Federal Government and the employees.

For these reasons the Commission strongly urges enactment at an early date of H.R. 2931.

The Office of Management and Budget advises that from the standpoint of the administration's program there is no objection to the submission of this report.

By direction of the Commission:

Sincerely yours,

ALAN K. CAMPBELL,
Chairman.

[*8] CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 8902 OF TITLE 5, UNITED STATES CODE

§ 8902. Contracting authority

(a) * * *

* * * * *

(m) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

[*1]

95TH CONGRESS *2d Session*

SENATE

REPORT No. 95-903

UNIFORMITY IN FEDERAL EMPLOYEE HEALTH BENEFITS AND COVERAGE

MAY 18, 1976 (legislative day, MAY 17), 1978.—
Ordered to be printed

Mr. SASSER, from the Committee on Governmental Affairs,
submitted the following

REPORT

[To accompany H.R. 2931]

The Committee on Governmental Affairs, to which was referred the bill (H.R. 2931) to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

AMENDMENTS

The amendments are as follows:

Amend the title to read as follows:

To amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage by preempting certain inconsistent State or local laws while recognizing the rights of States to determine who is to provide health services.

On page 1, line 7, strike out "(m)" and insert in lieu thereof "(m) (1)".

On page 2, line 5, strike out the closing quotation marks and the end period.

On page 2, immediately after line 5, insert the following:

(2) (A) Notwithstanding the provisions of paragraph (1), if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health [*2] services for the care and treatment of any particular health condition other than a mental health condition, the carrier shall provide, pay, or reimburse for any such health service properly provided by a person licensed under State law to provide such service.

(B) The provisions of this paragraph shall not apply to group practice prepayment plans.

On page 2, after line 5, insert the following new section:

SEC. 2. Section 8901(8) of title 5, United States Code, is amended by striking out "before January 1, 1964" and inserting in lieu thereof "after December 31, 1978, and before January 1, 1980".

PURPOSE

The purpose of H.R. 2931, as amended, is to establish uniformity in benefits and coverage under the Federal employees' health benefits program by providing that the provisions of any contract under such program shall supersede and preempt any State or local law or regulation that is inconsistent with such contractual provisions. At the same time, however, the purpose is to recognize the rights of States to determine who is to provide health services.

The bill also amends section 8901(8) of title 5, United States Code, to permit an employee organization, as defined under the section, to apply, after December 31, 1978, and before January 1, 1980, to the Civil Service Commission for approval of a health benefit plan.

HEARINGS

Hearings on H.R. 2931 were held by the Subcommittee on Civil Service and General Services on September 14, 1977. Appearing in support of the bill were: Mr. Thomas Tinsley, Director, Bureau of Retirement, Insurance and Occupational Health, U.S. Civil Service Commission; and Mr. Malcolm McIntyre, director, Government Relations Division, Aetna Life and Casualty Co. Appearing in opposition to the bill were: Dr. Robert B. Shelton, president, United Chiropractors of North America; Dr. Paul Parrott, American Chiropractic Association; and Mr. Herbert Anderson, the National Association of Insurance Commissioners.

Thereafter, the subcommittee amended the bill as described above and recommended favorable action by the full committee on the bill, as amended, on May 9, 1978.

BACKGROUND

The Federal employees' health benefits (FEHB) program, established by the Federal Employees' Health Benefits Act of 1959, now codified in chapter 89 of title 5, United States Code, provides health insurance coverage for about 3 million Federal employees and annuitants and 6 million dependents. The contracts negotiated between the Civil Service Commission and the various FEHB carriers are required to provide the same benefits for the same premium for all enrollees in a particular plan. The contracts specify the benefits to be [*3] provided by the various plans and the premium cost which is shared by the government and the enrollees.

The total cost of the program in fiscal year 1976 approximately $2.2 billion of which amount the government contributed approximately $1.4 billion. The total cost of the program for fiscal year 1977 will be about $2.5 billion.

According to the Comptroller General, as documented in his October 17, 1975, report to the Congress entitled 'Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employee Health Benefits Carriers':

(1) some doubt and confusion exists among the carriers and the States regarding the applicability of state requirements to FEHB contracts, and

(2) the States are becoming increasingly active in establishing and enforcing health insurance requirements.

As a result of these findings, the Comptroller General recommended that the Congress consider legislation to clarify the applicability of State insurance requirements to FEHB contracts.

Some States have established health insurance requirements that conflict with the provisions of the FEHB contracts, such as requiring recognition of certain practitioners not covered by Federal employee's health benefits plans. Many States have not attempted to enforce their requirements that conflict with the FEHB plans. In other States, the carriers have been successful in convincing the States that the Federal employees' plans are exempt from State requirements. Other States have enforced their requirements but have not done so uniformly for all carriers in the Federal program.

For example, the indemnity benefit plan (Aetna) pays for chiropractice services in Nevada as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractice services only in New York and Montana where State law requires coverage for such services. The services benefit plan has been required to pay for these services only in Maryland and Oklahoma. Even in the States that have enforced conflicting requirements, few Federal enrollees are aware of the States' requirements, and, as a result, most enrollees do not attempt to obtain reimbursement for chiropractice services.

As a result of this situation, officials of the Civil Service Commission asked the General Counsel of the Commission to review the law and furnish legal opinion on the question of the dominance of the Federal Employees' Health Benefits law over State and local laws. The General Counsel's conclusion was that, based on the Supremacy clause of the Constitution, the Federal Employee's Health Benefits law preempts State and local laws in this area. While the Commission has adopted the views of its General

Counsel, the Commission has advised the committee as follows:

The Commission adopted the views of the general counsel that the Federal Employees Health Benefits Act preempts State laws in this area. The Commission realizes that enforcement of this preemption policy will almost inevitably lead to time consuming and costly litigation with the States until its [*4] position is finally upheld by the courts. We do not view this as necessary or desirable. H.R. 2931 while it has more limited applicability does provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in the plan and enables the Commission, acting on behalf of the Government, to administer the Federal Employees Health Benefits Act in a reasonable and efficient manner. Furthermore, enactment of H.R. 2931 should result in a reduction in cost to the Federal Government and the employees.

COMMITTEE ACTION

H.R. 2931, as amended, guarantees that the provisions of health benefits contracts made under chapter 89, of title 5, United States Code, concerning benefits or coverage, would preempt any State and/or local insurance laws and regulations which are inconsistent with such contracts. Such a preemption, however, is purposely limited and will not provide insurance carriers under the program with exemptions from State laws and regulations governing other aspects of the insurance business such as the payment of premium taxes and requirements for statutory reserves.

H.R. 2931 is needed not only to clear up the doubt and confusion which exists among the carriers

and States, but also to clarify the Federal Government's and the Civil Service Commission's authority to regulate implementation of the law. As stated by the Civil Service Commission:

> While the FEHB law gives the Civil Service Commission the sole authority to negotiate contracts with participating carriers and to prescribe regulations to implement that law, the law does not give the Commission clear authority to issue regulations restricting the application of State laws when their provisions do not parallel the provisions in the Commission's health benefits contracts. The legislative history of the FEHB law is essentially silent on this point.

The committee also feels that a State's authority to control the licensing of health practitioners should also be preserved. As a result, an amendment was adopted which is designed to preserve certain States' authority by compelling insurance carriers to pay for any services which are contracted for if they are provided by a practitioner certified by the State to provide such services.

The amendment simply reserves to the States the right to determine who is and who is not qualified to provide health care; it encourages more innovative health techniques; it treats all health practitioners who treat the same conditions in an equitable manner: and it does not apply to mental health since existing Federal law already restricts payment to psychiatrists and clinical psychologists. (5 U.S.C., 8902(k))

A further modification to the bill allows employee organizations, as defined in section 8901(8) of title 5,

United States Code, to apply after December 31, 1978, and before January 1, 1980, to the Civil Service [*5] Commission for approval of a health benefit plan. Such organizations have been, in effect, barred from applying to the Commission for a health benefit plan unless they applied before January 1, 1964. This change, however, should not be considered as a reflection upon the merits of any new plan which may be applied for, as it merely allows the Civil Service Commission to review new proposals and to judge whether or not they meet the requirements necessary for Federal employee health benefits programs.

SECTION-BY-SECTION ANALYSIS

H.R. 2931, as amended, is an amendment to title 5, United States Code.

Section 1.—Amends section 8902 of Chapter 89, relating to contracts for Federal employee health benefits plans, by adding a new subsection (m) at the end thereof. The new subsection first provides that the provisions of any health benefit contract under chapter 89, shall supersede and preempt any State or local law, or any regulation issued under such law, relating to health insurance or plans, to the extent that such law or regulation is inconsistent with the provisions of the Federal employees' health benefits contract. The new subsection also provides for the treatment of any particular health condition other than a mental health condition, if such service is properly provided by a person licensed under State law to provide such service.

Section 2.—Amends section 8901(8) of title 5, United States Code, to permit an "employee organization." as defined under this section, to apply after

December 31, 1978, and before January 1, 1980, to the Civil Service Commission for approval of a health benefit plan.

ESTIMATED COST

Set forth below is a statement furnished by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE,
U.S. CONGRESS,
Washington, D.C., May 9, 1978.

Hon. ABRAHAM RIBICOFF,
Chairman, Committee on Governmental Affairs, Dirksen Senate Office Building, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has reviewed H.R. 2931, a bill to amend chapter 89 of title 5, United States Code, to establish a uniformity in Federal employee health benefits and coverage by preempting certain inconsistent State or local laws while recognizing the rights of States to determine who is to provide health services, as ordered reported by the Senate Committee on Governmental Affairs, May 9, 1978.

This bill requires that the provisions of contracts governing Federal health coverage and supersede State and local laws. Enactment of this bill could result in cost savings to the Government, through lower insurance premiums resulting from fewer contract ne-[*6]gotiations and from elimination of health in-

surance coverage required by some States but not by the Federal Government.

Should the committee so desire, we would be pleased to provide further details on this cost estimate.

Sincerely,

ROBERT A. LEVINE,
Deputy Director.

EVALUATION OF REGULATORY, PAPERWORK, AND PRIVACY IMPACT

Pursuant to rule 39 of the Standing Rules of the Senate, the committee anticipates that this legislation will have no adverse impact upon regulatory function, paperwork, or the privacy of any individual.

AGENCY COMMENTS

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET.
Washington, D.C., September 1, 1977.

Hon. ABRAHAM RIBICOFF,
Chairman, Committee on Governmental Affairs, U.S. Senate, Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to the committee's request for the views of this office on H.R. 2931, to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with

such contracts as passed by the House of Representatives on June 20, 1977.

The purpose of this bill is to exempt the Federal employees health benefits (FEHB) program from State or local laws or regulations to the extent they conflict with the provisions of an FEHB contract in order to ensure that benefits and coverage under the program will be uniform.

In its report, the Civil Service Commission states a number of reasons for supporting enactment of this bill.

We concur in the views expressed by the Civil Service Commission and, accordingly, recommend enactment of H.R. 2931.

Sincerely,

JAMES M. FREY,
Assistant Director for Legislative Reference.

U.S. CIVIL SERVICE COMMISSION,
Washington D.C., August 26, 1977.

Hon. ABRAHAM A. RIBICOFF,
Chairman, Committee on Governmental Affairs,
U.S. Senate, Washington. D.C.

DEAR MR. CHAIRMAN: The Commission is voluntarily submitting a report on H.R. 2931, a bill to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and cover-[*7]age provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage

which are inconsistent with such contracts. H.R. 2931 was passed by the House of Representatives on June 20, 1077.

H.R. 2931 would exempt the Federal employees health benefits program from any State or local law or regulation to the extent that such law or regulation conflicted with the provisions of the Federal Employees Health Benefits Act, regulations issued to contracts negotiated thereunder insofar as they pertain to benefits and coverage. It would not, as we read it, exempt the insurance carriers under the Federal employees health benefits programs from the payments of State premium taxes. State requirements for statutory reserves or other such regulations pertaining to the regulation of insurance within the State. It is a form of limited preemption.

The bill would statutorily establish uniformity of benefits and coverage under the Federal employees health benefits program as well as solve the other problems encountered in recent years in the administration of the program. The Commission strongly urges favorable consideration of the bill.

All States regulate the health insurance business in various and varying ways. During the early years of the Federal employees health benefits program, our plans and contracts were either in compliance with these laws and regulations or the States elected not to enforce laws that conflicted with our plans. Whatever the reason, State laws offered few if any problems for our program. Over the past several years, however, more and more States have legislated the kinds of benefits and medical practitioners that carriers doing business in these States must cover. These laws in effect presented serious problems from the standpoint of the uniformity of bene-

fits under the program. It also placed carriers in serious jeopardy of loss of their license in a State unless they were to approve payment for a benefit not provided under our contract but required by State law. The problem was complicated by the fact that if the Indemnity Benefit Plan carrier, Aetna, lost their license to provide health insurance in those States or in any State they would no longer be eligible as a carrier under the Federal employees health benefits law since the law (5 U.S.C. 8902(b)) requires them to be licensed in all 50 States and the District of Columbia. We would have no Government-wide Indemnity Benefit Plan. In addition to legislation and regulations applying to the kinds of benefits and medical practitioners that must be recognized, many States went further in requiring not only specific types of care but the extent of benefits, family members to be covered, the age limits for family members, extension of coverage, the format and the type of informational material that must be furnished, including in some instances the type of language to be used, extension of coverage and the type of conversion contracts that must be offered. The problem was further compounded by numerous State laws being made extraterritorial. The effect which these conflicting State laws had on our program was that if we were to continue or our carriers were to continue to be subject to State law the benefits provided to Federal employees could not be uniform throughout the Country and were largely determine on the basis of what State the employee either resided in or worked in. In terms of contracting with the carrier, it was reaching a point where unless we were to negotiate contracts that included all the requirements of the various State laws and applied them nationwide, we would continue to [*8] place our carriers in

a position where they would not be in compliance with some State law. In addition, many of the State laws were in conflict with one another. It appeared that under these circumstances the only solution to the problem would lie in negotiating contracts for Federal employees in each State and issuing separate brochures to meet individual State requirements.

Confronted with this situation the General Counsel of the Commission was asked to review the law and furnish a legal opinion on the question of the dominance over State and local laws of the Federal Employees Health Benefits Act. The General Counsel's conclusion was that "the supremacy clause creates an immunity from State interference of Federal operations. The principles underlying the need for national uniformity in the administration of Federal functions operate to supersede conflicts, arising from State laws and apply with equal regard to the Commission's administration of the Federal Employees Health Benefits Act. The McCarran-Ferguson Act by its terms and the interpretation of the courts in no way diminishes the supremacy of the Federal Employees Health Benefits Act over State laws. If the Commission is to have a free hand it needs to administer the Federal Employees Health Benefits Act, no other conclusion can be reached."

The Commission adopted the views of the General Counsel that the Federal Employees Health Benefits Act preempts State laws in this area. The Commission realizes that enforcement of this preemption policy will almost inevitably lead to time-consuming and costly litigation with the States until its position is finally upheld by the courts. We do not view this as necessary or desirable. H.R. 2931 while

it has more limited applicability does provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in the plan and enables the Commission, acting on behalf of the Government, to administer the Federal Employees Health Benefits Act in a reasonable and efficient manner. Furthermore, enactment of H.R. 2931 should result in a reduction in cost to the Federal Government and the employees.

For these reasons the Commission strongly urges enactment at an early date of H.R. 2931.

The Office of Management and Budget advises that from the standpoint of the administration's program there is no objection to the submission of this report.

By direction of the Commission:
Sincerely yours,

ALAN K. CAMPBELL,
Chairman.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., September 9, 1977.

B-164562.
Hon. ABRAHAM RIBICOFF,
Chairman, Committee on Governmental Affairs, U.S. Senate.

DEAR MR. CHAIRMAN: This is in response to your request for our comments on H.R. 2931, which provides that contracts between the [*9] Civil Service Commission and health plan carriers for the Federal employee health benefits program shall preempt

State and local laws which conflict with such contracts.

In our report, "Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers," MWD-76-49, dated October 17, 1975, we discussed a number of State health insurance laws, regulations, and Attorney General's opinions which were impacting on the coverage provided under Federal employee health plans. We concluded that because States were becoming more active in establishing and enforcing health insurance requirements which conflicted with the Civil Service Commission's contracts with Federal employees health plan carriers, such requirements could be expected to result in

> increased premium costs to both the Government and Federal employees, and
>
> a lack of uniformity of benefits for all enrollees in the same health plan, since enrollees in some States would be paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

We recommend to the Subcommittee on Retirement and Employment Benefits, House Committee on Post Office and Civil Service, that it consider legislation to clarify whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act.

H.R. 2931 is responsive to our recommendation and should help contain increasing Federal employee health plan premium costs, as well as provide uniformity and equity in benefit coverage. Accordingly, we favor passage of H.R. 2931.

Sincerely yours,

ROBERT F. KELLER,
Deputy Comptroller General of the United States.

CHANGES IN EXISTING LAW

In compliance with subsection 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law L which no change is proposed is shown in roman; existing law proposed to be omitted is enclosed in black brackets; new matter is shown in italic):

TITLE 5, UNITED STATES CODE

* * * * * * *

Chapter 89—Health Insurance

* * * * * * *

Sec. 8902. Contracting authority

(a) * * *

* * * * * * *

(m) (1) The provisions of any contract under this chapter which *relate to the nature or extent of coverage or benefits (including pay-*[*10]*ments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.*

"(2) (A) Notwithstanding the provisions of paragraph (1), if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care

and treatment of any particular health condition other than a mental health condition, the carrier shall provide, pay, or reimburse for any such health service properly provided by a person licensed under State law to provide such service.

"(B) The provisions of this paragraph shall not apply to group practice prepayment plans.".

*SEC. 8901 * * **

(8) "employee organization" means an association or other organization of employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter and which, [before January 1, 1964] "after December 31, 1978, and before January 1, 1980" applied to the Commission for approval of a plan provided under section 8903(3) of this title.

[*1]

105TH CONGRESS *1st Session* | HOUSE OF REPRESENTATIVES | REPORT 105-374

FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1997

NOVEMBER 4, 1997.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. BURTON of Indiana, from the Committee on Government Reform and Oversight, submitted the following

REPORT

[To accompany H.R. 1836]

[Including cost estimate of the Congressional Budget Office]

The Committee on Government Reform and Oversight, to whom was referred the bill (H.R. 1836) to amend chapter 89 of title 5, United States Code, to improve administration of sanctions against unfit health care providers under the Federal Employees Health Benefits Program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

[*2] Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Employees Health Care Protection Act of 1997".

SEC. 2. DEBARMENT AND OTHER SANCTIONS.

(a) AMENDMENTS.—Section 8902a of title 5, United States Code, is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking "and" at the end of subparagraph (B);

(ii) by striking the period at the end of subparagraph (C) and inserting "; and"; and

(iii) by adding at the end the following:

"(D) the term 'should know' means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;"; and

(B) in paragraph (2)(A), by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)";

(2) in subsection (b)—

(A) by striking "The Office of Personnel Management may bar" and inserting "The Office of Personnel Management shall bar"; and

(B) by amending paragraph (5) to read as follows:

"(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).";

(3) by redesignating subsections (c) through (d) as subsections (d) through (j), respectively, and by inserting after subsection (b) the following:

"(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

"(1) Any provider—

"(A)whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

"(B)that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

"(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

"(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

"(4) Any provider that the Office determines, in connection with claims presented under this

chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

"(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.";

(4) in subsection (d) (as so redesignated by paragraph (3)) by amending paragraph (1) to read as follows: [*3]

"(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

"(A) an item or service not provided as claimed,

"(B) charges in violation of applicable charge limitations under section 8904(b), or

"(C) an item or service furnished during a period in which the provider was debarred

from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);";

(5) in subsection (f) (as so redesignated by paragraph (3)) by inserting after "under this section" the first place it appears the following: "(where such debarment is not mandatory)";

(6) in subsection (g) (as so redesignated by paragraph (3))—

(A) by striking "(g)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

"(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).";

(B) in paragraph (3)—

(i) by inserting "of debarment" after "notice"; and

(ii) by adding at the end the following: "In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).";

(C) in paragraph (4)(B)(i)(I) by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)"; and

(D) by striking paragraph (6);

(7) in subsection (h) (as so redesignated by paragraph (3)) by striking "(h)(1)" and all that follows through the end of paragraph (2) and inserting the following:

"(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

"(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion."; and

(8) in subsection (i) (as so redesignated by paragraph (3))—

(A) by striking "subsection (c)" and inserting "subsection (d)"; and [*4]

(B) by adding at the end the following: "The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or

later owing by the United States to the party against whom the penalty or assessment has been levied.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) EXCEPTIONS.—(A) Paragraphs (2), (3), and (5) of section 8902a(c) of title 5, United States Code, as amended by subsection (a)(3), shall apply only to the extent that the misconduct which is the basis for debarment under such paragraph (2), (3), or (5), as applicable, occurs after the date of the enactment of this Act.

(B) Paragraph (1)(B) of section 8902a(d) of title 5, United States Code, as amended by subsection (a)(4), shall apply only with respect to charges which violate section 8904(b) of such title for items or services furnished after the date of the enactment of this Act.

(C) Paragraph (3) of section 8902a(g) of title 5, United States Code, as amended by subsection (a)(6)(B), shall apply only with respect to debarments based on convictions occurring after the date of the enactment of this Act.

SEC. 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES.

(a) DEFINITION OF A CARRIER.—Paragraph (7) of section 8901 of title 5, United States Code, is amended by striking "organization;" and inserting "organi-

zation and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;".

(b) SERVICE BENEFIT PLAN.—Paragraph (1) of section 8903 of title 5, United States Code, is amended by striking "plan," and inserting "plan, which may be underwritten by participating affiliates licensed in any number of States,".

(c) PREEMPTION.—Section 8902(m) of title 5, United States Code, is amended by striking "(m)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.".

SEC. 4. CONTINUED HEALTH INSURANCE COVERAGE FOR CERTAIN INDIVIDUALS.

(a) ENROLLMENT IN CHAPTER 89 PLAN.—For purposes of chapter 89 of title 5, United States Code, any period of enrollment—

(1) in a health benefits plan administered by the Federal Deposit Insurance Corporation before the termination of such plan on January 3, 1998, or

(2) subject to subsection (c), in a health benefits plan (not under chapter 89 of such title) with respect to which the eligibility of any employees or retired employees of the Board of Governors of the Federal Reserve System terminates on January 3, 1998,

shall be deemed to be a period of enrollment in a health benefits plan under chapter 89 of such title.

(b) CONTINUED COVERAGE.—(1) Subject to subsection (c), any individual who, on January 3, 1998, is enrolled in a health benefits plan described in subsection (a)(1) or (2) may enroll in an approved health benefits plan under chapter 89 of title 5, United States Code, either as an individual or for self and family, if, after taking into account the provisions of subsection (a), such individual—

(A) meets the requirements of such chapter for eligibility to become so enrolled as an employee, annuitant, or former spouse (within the meaning of such chapter); or

(B) would meet those requirements if, to the extent such requirements involve either retirement system under such title 5, such individual satisfies similar requirements or provisions of the Retirement Plan for Employees of the Federal Reserve System.

Any determination under subparagraph (B) shall be made under guidelines which the Office of Personnel Management shall establish in consultation with the Board of Governors of the Federal Reserve System.

(2) Subject to subsection (c), any individual who, on January 3, 1998, is entitled to continued coverage under a health benefits plan described in subsection (a)(1) or (2) shall be deemed to be entitled to continued coverage under section 8905a of title 5, United States Code, but only for the same remaining period as would have been [*5] allowable under the health benefits plan in which such individual was enrolled on January 3, 1998, if—

(A) such individual had remained enrolled in such plan; and

(B) such plan did not terminate, or the eligibility of such individual with respect to such plan did not terminate, as described in subsection (a).

(3) Subject to subsection (c), any individual (other than an individual under paragraph (2)) who, on January 3, 1998, is covered under a health benefits plan described in subsection (a)(1) or (2) as an unmarried dependent child, but who does not then qualify for coverage under chapter 89 of title 5, United States Code, as a family member (within the meaning of such chapter) shall be deemed to be entitled to continued coverage under section 8905a of such title, to the same extent and in the same manner as if such individual had, on January 3, 1998, ceased to meet the requirements for being considered an unmarried dependent child of an enrollee under such chapter.

(4) Coverage under chapter 89 of title 5, United States Code, pursuant to an enrollment under this section shall become effective on January 4, 1998.

(c) ELIGIBILITY FOR FEHBP LIMITED TO INDIVIDUALS LOSING ELIGIBILITY UNDER FORMER HEALTH PLAN.—Nothing in subsection (a)(2) or any paragraph of subsection (b) (to the extent such paragraph relates to the plan described in subsection (a)(2)) shall be considered to apply with respect to any individual whose eligibility for coverage under such plan does not involuntarily terminate on January 3, 1998.

(d) TRANSFERS TO THE EMPLOYEES HEALTH BENEFITS FUND.—The Federal Deposit Insurance Corporation and the Board of Governors of the Fed-

eral Reserve System shall transfer to the Employees Health Benefits Fund under section 8909 of title 5, United States Code, amounts determined by the Director of the Office of Personnel Management, after consultation with the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System, to be necessary to reimburse the Fund for the cost of providing benefits under this section not otherwise paid for by the individuals covered by this section. The amounts so transferred shall be held in the Fund and used by the Office in addition to amounts available under section 8906(g)(1) of such title.

(e) ADMINISTRATION AND REGULATIONS.—The Office of Personnel Management—

(1) shall administer the provisions of this section to provide for—

(A) a period of notice and open enrollment for individuals affected by this section; and

(B) no lapse of health coverage for individuals who enroll in a health benefits plan under chapter 89 of title 5, United States Code, in accordance with this section; and

(2) may prescribe regulations to implement this section.

SEC. 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS.

The Office of Personnel Management shall encourage carriers offering health benefits plans described by section 8903 or section 8903a of title 5, United States Code, with respect to contractual arrangements made by such carriers with any person

for purposes of obtaining discounts from providers for health care services or supplies furnished to individuals enrolled in such plan, to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SEC. 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP.

(a) AUTHORITY TO READMIT.—

(1) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by inserting after section 8903a the following:

"§ 8903b. Authority to readmit an employee organization plan

"(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

"(b) A contract for a plan approved under this section shall require the carrier—

"(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

"(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.".

[*6] (2) CONFORMING AMENDMENT.—The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8903a the following:

"8903b. Authority to readmit an employee organization plan.".

(3) APPLICABILITY.—

(A) IN GENERAL.—The amendments made by this subsection shall apply as of the date of enactment of this Act, including with respect to any plan which has been discontinued as of such date.

(B) TRANSITION RULE.—For purposes of applying section 8903b(a) of title 5, United States Code (as amended by this subsection) with respect to any plan seeking to be readmitted for purposes of any contract year beginning before January 1, 2000, such section shall be applied by substituting "second contract year" for "third contract year".

(b) TREATMENT OF THE CONTINGENCY RESERVE OF A DISCONTINUED PLAN.—

(1) IN GENERAL.—Subsection (e) of section 8909 of title 5, United States Code, is amended by striking "(e)" and inserting "(e)(1)" and by adding at the end the following:

"(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

"(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied

in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.".

(2) TRANSITION RULE.—In the case of any amounts remaining as of the date of enactment of this Act in the contingency reserve of a discontinued plan, such amounts shall be disposed of in accordance with section 8909(e) of title 5, United States Code, as amended by this subsection, by—

(A) the deadline set forth in section 8909(e) of such title (as so amended); or

(B) if later, the end of the 6-month period beginning on such date of enactment.

SEC. 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE.

(a) IN GENERAL.—Paragraph (2) of section 5948(a) of title 5, United States Code, is amended by striking "$20,000" and inserting "$30,000".

(b) AUTHORITY TO MODIFY EXISTING AGREEMENTS.—

(1) IN GENERAL.—Any service agreement under section 5948 of title 5, United States Code, which is in effect on the date of enactment of this Act may, with respect to any period of service remaining in such agreement, be modified based on the amendment made by subsection (a).

(2) LIMITATION.—A modification taking effect under this subsection in any year shall not cause an allowance to be increased to a rate which, if applied throughout such year, would cause the limitation under section 5948(a)(2) of

such title (as amended by this section), or any other applicable limitation, to be exceeded.

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be considered to authorize additional or supplemental appropriations for the fiscal year in which occurs the date of enactment of this Act.

SEC. 8. CLARIFICATION RELATING TO SECTION 8902(k).

Section 8902(k) of title 5, United States Code, is amended—

(1) by redesignating paragraph (2) as paragraph (3); and

(2) by inserting after paragraph (1) the following:

"(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.".

I. SUMMARY OF LEGISLATION

H.R. 1836, as amended by the Committee, amends several provisions in title 5, United States Code. It provides the Office of Personnel Management (OPM) additional tools to fight waste, fraud, and abuse in the Federal Employees Health Benefits (FEHB) program. With these tools, OPM will be able to deal swiftly with [*7] health care providers who try to defraud the FEHB program. OPM will be better equipped to bar health care providers who engage in misconduct from participating in the FEHB program or to impose monetary penalties on them. The bill

also provides that an association of organizations may underwrite health care plans in the FEHB program, and it broadens the current statutory language preempting State insurance laws.

In addition, the bill permits certain employees of the Federal Deposit Insurance Corporation (FDIC) and the Federal Reserve Board (Fed) to participate in the FEHB program, and it requires OPM to encourage carriers who contract with third parties to obtain discounts from health care providers to seek assurances that the conditions for the discounts are fully disclosed to such providers. It also establishes statutory requirements for readmitting health care plans sponsored by employee organizations that have previously discontinued participation in the FEHB program. Under current law, when a health care plan discontinues participation in the FEHB program, OPM must credit that plan's remaining contingency reserves to those plans that remained in the FEHB program in the contract year after the discontinuance. This bill requires OPM to complete the distribution by the end of the second contract year after the plan is discontinued.

The maximum amount of the physicians comparability allowance under 5 U.S.C. § 5948 is increased from $20,000 to $30,000.

The bill also amends 5 U.S.C. § 8902(k) to explicitly permit carriers to provide for direct access and direct payments to licensed health care providers who are not currently enumerated in the statute.

II. BACKGROUND AND NEED FOR THE LEGISLATION

SECTION 1

H.R. 1836 was introduced by Mr. Burton of Indiana to strengthen the integrity and standards of the FEHB program and allow it to maintain its reputation as a high quality and cost-effective program. The FEHB program is the largest employer-sponsored health insurance system in the country. In 1997, the $16 billion FEHB program will insure more than nine million Federal employees, retirees, and their dependents. Partial portability, the absence of preexisting condition limitations, and an annual open enrollment period are facets of the FEHB program that make it an extremely attractive health care system. The program's market orientation has effectively contained costs through private sector competition with limited governmental intervention. The program is often cited as a model of efficiency and effectiveness that the private sector and the public sector should attempt to replicate. This bill will improve the program and its performance without changing the market principles that are the key to its success.

SECTION 2

Section 2 of this bill addresses the debarment of health care providers engaging in fraudulent practices. This provision would strengthen the ability of OPM to bar health care providers who engage in professional and or financial misconduct from participating [*8] in the FEHB program or to impose monetary penalties on them. Under this bill, the administrative sanctions authority would conform more closely with provisions of Medicare law. The paral-

lels between these provisions and Medicare law should benefit not only OPM, but also carriers and health care providers, who are already familiar with interpretations and practices under similar Medicare provisions.

In addition, this bill streamlines the debarment process by generally permitting OPM to debar a provider before a hearing is held. However, upon request, the provider would be entitled to an administrative hearing after an adverse de-termination is made if the provider shows that due process rights were not previously afforded with respect to any finding of fact which is relied upon as a cause for the adverse de-termination. The hearing will be held before a hearing officer who shall be designated by the Director of OPM and conducted without regard to the requirements of subchapter II of chapter 5 and chapter 7 of title 5, United States Code. Judicial review shall lie with the United States District Court for the District of Columbia or other appropriate district, rather than, as under current law, with the United States Court of Appeals for the Federal Circuit.

Under current law, OPM is permitted to debar health care providers on certain grounds, but it is not required to do so. This bill makes debarment mandatory if a health care provider is convicted of certain criminal offenses or is currently debarred, suspended or otherwise excluded from any procurement or nonprocurement activity within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994.

OPM retains its existing authority to debar health care providers on grounds relating to professional licensing, and this bill adds four additional grounds for permissive debarment, including the determina-

tion that a provider has charged substantially more than the provider's customary charge for health care services or supplies without good cause, or has charged for substandard or medically unnecessary health care services or supplies. The determination that a service or supply is medically unnecessary must be made by trained reviewers on the basis of written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, OPM must consult a physician in an appropriate specialty. These trained reviewers may be employees of OPM, other appropriately trained Federal employees, or contractors.

Existing law does not mandate a minimum period of debarment. This bill, however, requires that providers convicted under Federal or State law of certain offense must be de-barred for at least 3 years.

Under current law, OPM, in consultation with the Attorney General, may impose a civil monetary penalty of up to $10,000 on a health care provider guilty of certain misconduct. This bill modifies the grounds upon which OPM may assess such penalties. OPM's authority to impose a monetary penalty on health care providers for excessive charges or charges for substandard or medically unnecessary services or supplies is deleted. (That misconduct becomes, instead, grounds for permissive debarment.) But it is given [*9] additional authority to impose a civil penalty for charges exceeding Medicare limitations in violation of 5 U.S.C. §8904(b) or charging for items or services provided during a period of debarment.

These modifications of OPM's authority to debar health care providers and impose monetary penalties upon them will strengthen OPM's ability to protect the FEHB program—and the employees and retirees

who depend upon it—from fraudulent or abusive practices that drive up health care costs and premiums.

SECTION 3

The bill amends the definition of "carrier" and the description of the government-wide Service Benefit Plan under current law. The revised definition makes clear that an association of organizations, or other entities, may be the carrier for any health benefits plan in the FEHB program. The new description makes clear that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia. Indeed, although the government-wide Service Benefit Plan historically has been underwritten by all of the affiliates of the sponsoring association, the withdrawal of an affiliate in a State would not affect the sponsoring association's ability to continue offering the plan in that State.

In addition, this bill broadens the preemption provisions in current law to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live. This change will strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts. It will also prevent carriers' cost-cutting initiatives from being frustrated by State laws. For example, a carrier's effort to establish a preferred provider organization (PPO) across the country would not be jeopardized by State-mandated "any willing provider" statutes.

SECTION 4

Another important component of this bill provides consistent health benefit coverage for individuals

who were covered by health care plans offered by the Board of Governors of the Federal Reserve System (Fed) or the Federal Deposit Insurance Corporation (FDIC). A number of years ago, the Fed decided to drop out of the FEHB program and sponsor a separate health care plan for its employees. But in 1993, the Fed elected to abandon this health care experiment and offer its employees only FEHB program coverage. The Fed per-mitted some retirees and employees to participate in a health care plan offered by one of the Federal Reserve Banks because current law generally requires five years of continuous enrollment in the FEHB program before individuals may participate in it after retirement. Consequently, some current employees approaching retirement age and a number of individuals who retired while the Fed had its own system are not eligible to participate in the FEHB program during retirement. The FDIC faces a similar situation because it plans to eliminate its alternative health insurance plan at the end of 1997. Without this legislation, the FDIC and the Fed will have to establish a non-FEHB program plan for those employees who are ineligible for coverage. This would be administratively burdensome and costly to these Federal agencies [*10] and, ultimately, to the taxpayers. Under this proposal, these ineligible employees would be offered FEHB program coverage at no additional cost to the Government.

SECTION 5

The Committee has received complaints from numerous providers doing business with health plans in the Federal Employees Health Benefits (FEHB) program about dubious, and possibly unethical, practices in which discounts are taken without contractual rights or on a basis other than negotiated or

agreed to by contract. The genesis of these complaints to the Committee coincide with the insertion of language in the Office of Personnel Management's (OPM) annual FEHB call letter which appears to have had the effect of increasing these dubious practices in the FEHB program.

Organizations that take advantage of health care providers by arranging for a carrier to obtain access to discounted rates they are not entitled to are the focus of Section 5 of H.R. 1836. The first victims of this practice are the doctors and hospitals. But in the end, all of us pay the price as the losses incurred by these providers are shifted to other consumers of medical services. Eventually this cost shifting will lead to higher prices for medical services, higher insurance premiums, or a decline in the quality of services available.

The Committee's sole interest is in ensuring that the integrity of the FEHB program is maintained and that the imprimatur of the United States Government is not used in any way to encourage or condone an unethical health care practice within the FEHB program. The Committee strongly believes that the full disclosure of discounted rate agreements is necessary to protect not just health care providers, but more importantly, the very integrity of the FEHB program. The Committee does not intend to interject the Government into the contracting arrangements between private sector health care providers, vendors and health plans; nor is it the role of the Government to ensure that either party negotiates a con-tract to its advantage. The Committee, however, does expect OPM to be aware of dubious practices in the health care industry and to be cogni-

zant of the influence of its directives to FEHB plans on those practices.

The language included in Section 5 of the bill as introduced, was modified during the mark up of the bill held on October 22, 1997 by the Subcommittee on Civil Service. As a result of further bipartisan discussion with the Office of Personnel Management, alternative language was drafted by OPM and was inserted into Section 5 during the full Committee Business Meeting held on October 31, 1997. The language provided to the Committee by OPM was adopted verbatim.

As a result of this action by the Congress, OPM is expected to clarify the instructions in its annual call letter to ensure that FEHB carriers understand that in obtaining provider discounts, the standard to be observed is not only one of cost-effectiveness, but ethical practices as well. Further, the Committee expects the Office of Personnel Management to respond appropriately to specific and credible complaints concerning discounts taken without disclosure of the conditions for such discounts. Finally, the Committee expects the Office of Personnel Management to be mindful [*11] of its own Federal Employees Health Benefits Acquisition Regulation (FEHBAR) promulgated at 48 Code of Federal Regulations 1609.7001 (b)(2) requiring legal and ethical business and health care practices in the performance of FEHB contracts.

SECTION 6

This bill also establishes rules under which a health care plan sponsored by an employee organization may reenter the FEHB program after previously discontinuing its participation. Under current law, such plans may not reenter. The bill will permit

such a plan to again participate in the FEHB program after the end of the third contract year following its discontinuance (2 contract years in the case of plans applying for a contract year beginning before January 1, 2000). This waiting period is necessary to discourage plans from leaving the FEHB program in order to eliminate their high risk policyholders and then quickly begin again with a clean slate. Such plans must also be underwritten by a subcontractor li-censed to issue group health insurance in all the States and the District of Columbia and demonstrate experience in service delivery within a managed care system.

In addition, this bill requires OPM to distribute the contingency reserves of certain discontinued plans within 2 contract years. Under current law, OPM is required to distribute those reserves to plans continuing in the FEHB program in the contract year after the discontinuance. OPM has interpreted the current statutory language to provide it with unlimited time in which to complete this distribution. The Committee believes, however, that OPM should be required to completely distribute these reserves in 2 years in order to offset the additional liabilities assumed by continuing plans.

SECTION 7

The bill also increases the maximum physicians comparability allowance Federal agencies may pay from $20,000 to $30,000 per year. In 1978, Congress enacted the Physicians Comparability Act of 1978 (PCA), which provides for such annual allowances, in response to a critical shortage of Federal physicians and income disparities between physicians employed by the Departments of Defense and Veterans Affairs and other Federal doctors. That Act has been reau-

thorized several times, most recently in H.R. 2541, the Fiscal Year 1998 Treasury, Postal, and General Government Services Appropriations Act. But the maximum allowance has not been increased since 1987, and the gap between special pay provisions for VA physicians and Federal doctors covered by the PCA has widened in the last four years. Federal physicians also earn considerably less than private sector doctors. But Federal physicians conduct research on AIDS, cancer, and heart disease; they protect the safety of food and drugs; and they perform many other valuable functions. The Committee believes the maximum allowance should be increased to ensure the Federal Government can recruit and retain highly-trained and well-qualified physicians to perform these important functions.

[*12] SECTION 8

Under current law, carriers offering health benefit plans under the FEHB program are required to provide for direct access and direct payments to certain enumerated health care providers. In recent years, some providers have argued that providers who are not specifically enumerated are placed at a competitive disadvantage in gaining access to the FEHB program market place. Nothing in the statute currently prevents carriers from voluntarily providing direct access or payments to other health care providers. Nevertheless, the Committee has been advised that on occasion this provision has been misconstrued to prohibit such arrangements. The bill will prevent such misreading of the statute in the future by explicitly permitting FEHB program carriers to provide direct access and direct payment to licensed health care providers who are not specifically identified in the statute.

III. Legislative Hearings and Committee Actions

H.R. 1836 was introduced on June 10, 1997 by the Honorable Dan Burton. The bill was referred to the Committee on Government Reform and Oversight on June 10, 1997, and it was referred to the Subcommittee on Civil Service on June 11, 1997. The subcommittee held a mark up on October 22, 1997. Representative Mica offered an amendment in the nature of a substitute. Representative Sessions offered an amendment to the amendment in the nature of a substitute, and Representative Morella offered two. The amendment offered by Representative Sessions and one of the amendments offered by Representative Morella, as well as the amendment in the nature of a substitute were adopted by voice votes. (The other amendment offered by Representative Morella was withdrawn.) The subcommittee favorably reported the bill, as amended, to the full Committee by a voice vote.

On October 31, 1997, the Committee on Government Reform and Oversight met to consider the bill as amended by the subcommittee. Chairman Burton offered an amendment in the nature of a substitute. The amendment in the nature of a substitute was adopted by voice vote. The Committee favorably reported the bill, as amended, to the full House by voice vote.

IV. Committee Hearings and Written Testimony

The Committee held no hearings and received no written testimony. However, the Subcommittee on Civil Service did examine the debarment provisions of H.R. 1836 and the issue of "silent PPOs" at an oversight hearing, "FEHB Rate Hikes—What's Behind Them?," on October 8, 1997. William E. Flynn,

III, OPM's Associate Director, Retirement and Insurance Service, testified that OPM supported the improved debarment procedures contained in this bill. Stephen W. Gammarino, Vice President, Federal Employee Programs, Blue Cross-Blue Shield Association, testified that the Blue Cross-Blue Shield Association does not support or use "silent PPOs" and does not believe their use should be required or mandated. He cautioned, however, against overregulation of rate agreements between carriers, networks, and health care providers as a method of controlling costs. The private sector, he testified, is much [*13] more innovative than government and can move much more quickly to control costs without government intervention.

V. Explanation of the Bill as Reported: Section-by-Section Analysis

Sec. 1. The short title of the bill is the Federal Employees Health Care Protection Act of 1997.

Sec. 2. This section amends 5 U.S.C. § 8902a regarding the Office of Personnel Management's (OPM) authority to debar or otherwise sanction health care providers in the Federal Employees Health Benefits Program (FEHBP).

Subsection (a)(1) adds a new paragraph to define the term "should know". Under this definition, the term means that a person acted in deliberate ignorance or with reckless disregard of the truth or falsity of information, and no proof of specific intent to defraud is required. This is the same definition given the term under Medicare law in 42 U.S.C. § 1320a–7a(7).

Subsections (a)(2)–(3) provide OPM with both permissive and mandatory authority to debar health

care providers. Under current law, OPM has only permissive authority to debar such providers for certain reasons.

Subsection (a)(2) requires OPM to debar health care providers under the following circumstances:

1. Conviction, under Federal or State law, relating to fraud, corruption, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care service or supply;

2. Conviction, under Federal or State law, relating to neglect or abuse of patients in connection with the delivery of a health care service or supply;

3. Conviction, under Federal or State law, in connection with the interference with or obstruction of a Federal or State investigation or prosecution of a criminal offense described in (1) or (2) above;

4. Conviction, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; and

5. Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or non-procurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1944).

Subsection (a)(3) permits OPM to debar:

1. Any provider whose license has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, profes-

sional performance, or financial integrity, or who surrendered his license while a formal disciplinary proceeding relating to one of these subjects was pending;

2. Any provider that is an entity owned, directly or indirectly, by an individual who is convicted of any offense that is a ground for mandatory debarment, against whom a civil monetary penalty has been assessed, or who has been debarred from participating in FEHB program, or in which such an individual holds a control interest of 5% or more; [*14]

3. Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action on which the sanction was based;

4. Any provider that OPM determines has charged substantially more than the provider's customary charge for health care services or supplies (unless OPM finds there is good cause for such charge), or has charged for substandard or medically unnecessary health care services or supplies; or

5. Any provider that OPM determines has committed acts for which a civil penalty may be imposed.

A determination under clause (4) above that a service or supply is medically unnecessary must be made by trained re-viewers on the basis of written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, OPM must consult a physician in an appropriate specialty. This requirement recognizes that the determination of whether services or sup-

plies are not medically necessary is a medical judgment. Accordingly, that judgment must be made by individuals trained in reviewing such medical questions and on the basis of protocols developed by physicians, not by bureaucrats. This requirement will not impose an undue burden on OPM. OPM may use appropriately trained employees of its own to review these matters, or they may take advantage of the broad expertise of the many trained medical personnel, including doctors, in the Federal workforce. OPM may also choose to contract with private organizations to perform some or all of these tasks.

Subsection (a)(4) modifies OPM's authority to impose a monetary civil penalty. Under current law, OPM can impose a penalty for several reasons, including OPM's determination that in connection with "a claim", a health care provider has (1) charged for services or supplies that the provider knows or should have known were not provided as claimed, or (2) charged substantially more than his customary charges or for substandard or medically unnecessary services or supplies. This subsection removes OPM's authority to impose a penalty based upon overcharges or substandard or medically un-necessary services or supplies. Instead, OPM is authorized to impose penalties based upon charges the provider knows or should have known exceeds Medicare limitations, as made applicable by 5 U.S.C. 8904(b), or were for an item or service furnished during a period when the provider was de-barred from participation in FEHB program, other than services permitted under subsection (g)(2)(B) (as redesignated by this bill). In addition, the word "claims" is substituted for the words "a claim."

Subsection (a)(5) revises current law to provide that OPM is not required to consider certain statutory criteria relating to the appropriateness of debarment when debarment is mandatory.

Subsection (a)(6) amends current law with respect to the effective date of debarment, the period of debarment, and the termination of debarment. With one exception, this subsection provides that mandatory or permissive debarment is effective at such time and upon reasonable notice to the provider, carriers, and covered individuals, as OPM shall specify in regulations. A debarred provider may request a hearing after debarment. Unless OPM determines that the health or safety of patients warrants an earlier effective [*15] date, OPM cannot make a determination adverse to a provider under its permissive debarment authority for acts for which a civil penalty may be imposed or under its authority to impose a civil penalty for acts for which such a penalty may be imposed until the provider has been given reasonable notice and an opportunity for the determination to be made after a hearing to be held before adverse action is taken. This subsection also establishes a minimum debarment period of 3 years for certain criminal convictions. Finally, this subsection also amends current law to permit OPM to terminate mandatory debarment after the minimum debarment period if it determines that there is no basis under mandatory debarment authority for continuing debarment.

Subsection (a)(7) amends provisions relating to the notice and hearing requirements and to judicial review. Under current law, OPM may not debar a provider or impose a monetary penalty until after the provider has been given written notice and an opportunity for a hearing on the record, and any person

affected by OPM's final adverse decision may obtain review in the United States Court of Appeals for the Federal Circuit. This subsection provides that a provider subject to an adverse determination by OPM is entitled to reasonable notice and an opportunity to request a hearing of record. OPM is required to grant a request for a hearing upon a showing that due process rights previously have not been afforded for any finding of fact relied upon as a cause for an adverse determination. The hearing is not subject to sub-chapter II of chapter 5 or chapter 7 of title 5, which relate to administrative procedures and judicial review. Judicial review is available in the United States District Court for the District of Columbia, or for the district in which the plaintiff resides or has his or her principal place of business. The district court may not set aside or remand an OPM decision unless there is not substantial evidence on the record, taken as a whole, to support the findings by OPM or unless OPM has abused its discretion.

Subsection (a)(8) amends current law regarding the collection of civil monetary penalties or assessments. Under this subsection, the amount of a penalty or assessment may be withheld from any sum then or later owed to the provider by the United States.

Subsection (b) establishes effective dates for the amendments made by this section. With three exceptions, these amendments take effect upon enactment. However, paragraphs (2), (3), and (5) of section 8902a(c), as amended by subsection (a)(3) of this Act, apply only to misconduct occurring after the date of enactment. Similarly, 5 U.S.C. 8902a(d)(1)(B), as amended by section (a)(4) of this Act, applies only with respect to charges for items or

services furnished after the date of enactment, and section 8902a(g)(3), as amended by subsection (a)(6)(B) of this Act, shall apply only to debarments based upon convictions occurring after the date of the enactment of this Act.

SEC. 3. Subsection (a) of this section amends 5 U.S.C. 8901(7) to make clear that an association of organizations, or other entities, may sponsor a health benefits plan, including the government-wide Service Benefit Plan and that the sponsor is the carrier. The Service Benefit Plan has been historically, and is currently, sponsored by an association whose members are lawfully engaged in provid-[*16]ing, paying for, or reimbursing the cost of group health plan functions. This revision conforms the statutory language to more clearly reflect this historical preference.

Subsection (b) amends section 8903 to make clear that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia. The carrier for this plan allocates its rights and obligations under the FEHB program contract among its affiliates which elect to participate. This revision makes clear that the withdrawal of an affiliate in a state would not affect the ability of the sponsoring association to continue offering the plan in that State.

Subsection (c) amends section 8902(m) to broaden the preemption of State and local laws with respect to health care contracts under the FEHB program. This amendment confirms the intent of Congress (1) that FEHB program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) complete-

ly displace State or local law relating to health insurance or plans and (2) that this preemption authority applies to FEHB program plan contract terms which relate to the provision of benefits or coverage, including managed care programs.

SEC. 4. This section permits certain individuals who have participated in health care plans established by the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System to participate in the FEHB program.

SEC. 5. This section requires OPM to encourage carriers who contract with third parties for discounted rates from health care providers to seek assurances that the conditions for those discounts have been fully disclosed to the health care providers.

SEC. 6. This section establishes rules under which employee-sponsored health plans that have discontinued participation in the FEHB program may be readmitted, and it compels OPM to distribute the contingency reserves of certain discontinued plans within 2 contract years. Under this subsection, a previously discontinued employee-sponsored plan may be allowed to participate in the FEHB program after the end of the third contract year following its discontinuance (2 contract years in the case of plans applying for a contract year beginning before January 1, 2000). Such plans must be underwritten by a subcontractor licensed to issue group health insurance in all the States and the District of Columbia and demonstrate experience in service delivery within a managed care system.

SEC. 7. This section increases the maximum physicians comparability payment under 5 U.S.C. § 5948 from $20,000 to $30,000.

SEC. 8. This section amends 5 U.S.C. § 8902(k) to make clear that carriers may voluntarily agree to provide direct access and direct payments to licensed health care providers even though such arrangements are not required by law.

VI. COMPLIANCE WITH RULE XI

Pursuant to rule XI, clause 2(l)(3)(A), of the Rules of the House of Representatives, under the authority of rule X, clause 2(b)(1) and clause 3(f), the results and findings for those oversight activities [*17] are incorporated in the recommendations found in the bill and in this report.

VII. BUDGET ANALYSIS AND PROJECTIONS

H.R. 1836, as amended, provides for no new authorization, budget authority, or tax expenditures. Consequently, the provisions of section 308(a) of the Congressional Budget Act are not applicable.

VIII. COST ESTIMATE OF THE CONGRESSIONAL BUDGET OFFICE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, November 3, 1997.

Hon. DAN BURTON,
Chairman, Committee on Government Reform and Over-sight, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1836, the Federal Employees Health Care Protection Act of 1997, as ordered reported by the House Committee on Government Reform and Oversight on October 31, 1997.

If you wish further details on these estimates, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

H.R. 1836—Federal Employees Health Care Protection Act of 1997

Summary: H.R. 1836 would modify the administration of Federal Employees Health Benefits (FEHB) and raise the pay of certain physicians employed by the federal government. CBO estimates that enacting this bill would increase federal outlays by $2 million in 1998 and by between $30 million and $35 million over the 1998–2002 period, assuming appropriation of the authorized amounts. Because the bill would not affect direct spending or receipts, pay-as-you-go procedures would not apply.

Section 2 would strengthen the Office of Personnel Management's (OPM's) ability to bar or sanction unethical health providers. Section 3 makes technical changes regarding national plans, and it would expand a preemption of state and local authority to regulate health care plans that provide coverage under FEHB. This preemption would represent a mandate under the Unfunded Mandates Reform Act of 1995, but CBO estimates that any costs to state or local governments arising from this mandate would be minimal.

Section 4 would allow retired employees of the Federal Deposit Insurance Corporation and the Federal Reserve Board access to FEHB plans. Section 5 would require OPM to encourage carriers who contract with third parties to obtain discounted rates

from health care providers to seek assurances that the conditions for those discounts have been fully dis-closed to the health care providers.

Section 6 clarifies FEHB procedures for the closure and readmittance of plans. Section 8 states that plans are allowed to provide [*18] direct access and payments to licensed health care providers, even when such arrangements are not required by law.

Section 7 would permit agencies to increase the maximum annual allowance payable to certain federal physicians from $20,000 to $30,000. CBO estimates that federal salary costs would increase by between $30 million and $35 million over the fiscal year 1998– 2002 period, subject to the availability of funds.

Estimated cost to the Federal Government: CBO estimates that enactment of H.R. 1836 would not affect federal outlays for FEHB, but would increase federal salary costs, subject to the availability of funds. For purposes of the estimate, CBO assumes that the bill will be enacted by the middle of fiscal year 1998 and that agencies would modify service agreements with physicians by year's end. The estimated costs of this legislation would affect several budget functions.

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002
SPENDING SUBJECT TO APPROPRIATION					
Spending on physicians comparability allowance under current law:					
Budget authority	27	27	27	27	14
Estimated outlays	27	27	27	27	14
Proposed changes:					
Estimated authorization level	2	9	9	9	5
Estimated outlays	2	9	9	9	5
Spending on physicians comparability allowance under H.R. 1836:					
Estimated authorization level	29	36	36	36	36
Estimated outlays	29	36	36	36	19

Basis of estimate

Spending for Federal employees health benefits

CBO estimates that H.R. 1836 would not significantly affect FEHB spending. The debarment and sanction provisions in Section 2 and the clarification

of federal preemption of state insurance laws in Section 3 could possibly reduce FEHB costs.

Section 5 could discourage some FEHB plans from using certain discount vendors, potentially increasing costs. Based on a survey conducted by the Office of Personnel Management, however, FEHB plans believe that their discount vendors provide disclosure of the conditions of the discounts to health providers.

Section 4 would allow OPM to determine payments from the Federal Deposit Insurance Corporation and the Federal Reserve Board to the FEHB fund such that giving enrollees in plans sponsored by those agencies access to FEHB plans would not affect federal spending.

Section 8 allows plans to make direct payments to certain non-physician providers. Because plans already have such authority, the enactment of that section would not change spending.

Physicians comparability allowance

Current law authorizes certain agencies to pay allowances of up to $20,000 a year to recruit and retain physicians for certain positions, such as those with long vacancies or high turnover rates. To receive the allowance, physicians must agree to work at least one year at the agency. CBO estimates that increasing the maximum [*19] annual allowance from $20,000 to $30,000 would increase salary costs by between $30 million and $35 million over the 1998–2002 period. This estimate is based on information provided by OPM, including data on the number of federal physicians receiving comparability allowances and the average annual premium that they receive under current service agreements. CBO estimates that the provision would increase the average

allowance for 1,800 physicians by about $5,000 a year.

The authority for agencies to offer allowances to physicians was recently extended through fiscal year 2000 by the Treasury and General Government appropriations bill for fiscal year 1998 (P.L. 105-61). Under that authority, agencies and physicians can enter into contracts that extend through the end of fiscal year 2002. Most service agreements are made for two years. CBO assumes that the number of outstanding contracts in fiscal year 2001 will approximate the number of contracts in 2000, and the number of contracts in fiscal year 2002 will be about one-half of the number estimated for 2001. Thus, the increase in costs for fiscal year 2002 is lower than for previous years.

Pay-as-you-go considerations: None.

Intergovernmental and private sector mandates: H.R. 1836 would expand the preemption of state and local authority to regulate health care plans that provide coverage under FEHB. Current law prohibits state and local governments from regulating the nature and extent of coverage and benefits for people covered by FEHB if the regulation or law is inconsistent with the contract provisions. The new language would preclude state and local governments from regulating the provision of coverage or benefits as well, and it removes the language dealing with inconsistencies, thereby giving the federal contract provisions clear authority. These changes would affect states that have comparably higher requirements for types of medical coverage offered by health plans. Although this preemption would be considered a mandate under UMRA, CBO estimates that

any costs to state or local governments arising from this mandate would be minimal.

Estimate prepared by: Federal Cost Estimate: Jeff Lemieux, FEHB; John R. Righter, federal pay. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on Private Sector: Sandra Christensen.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

IX. Specific Constitutional Authority for This Legislation

Pursuant to rule XI, clause 2(l)(4), the Committee finds that clauses 14 and 18 of Article 1, Section 8 of the U.S. Constitution grants Congress the power to enact this law.

X. Committee Recommendation

On October 31, 1997, a quorum being present, the Committee ordered the bill, as amended, favorably reported to the House for consideration.

[*20] Committee on Government Reform and Oversight—105th Congress Rollcall

Date: October 31, 1997.

Amendment No. 1.

Description: Amendment in the nature of a substitute.

Offered by: Mr. Dan Burton (IN).

Adopted by voice vote.

Final passage of H.R. 1836, as amended.

Offered by: Hon. Dan Burton (IN).

Adopted by voice vote.

XI. Congressional Accountability Act; Public Law 104-1; Section 102(B)(3)

The amendments made by H.R. 1836 will apply to employees and former employees of the legislative branch who participate in the Federal Employees Health Benefits Program to the same extent as it applies to other participating employees.

XII. Unfunded Mandates Reform Act; Public Law 104-4; Section 423

H.R. 1836, as amended, does not impose any Federal mandates on State, local, and tribal governments, or the private sector. Section 3(c) of the bill preempts any State and local law, and any regulations issued thereunder, that relates to health insurance or plans. The effect of these provisions is to permit health care plans participating in the FEHB program to offer uniform benefits nationwide because all questions relating to the nature, provision, or extent of coverage or benefits are to be determined by the terms of the contract between the carrier and OPM.

XIII. Federal Advisory Committee Act (5 U.S.C. App.) Section 5(b)

The Committee finds that the legislation does not establish or authorize establishment of an advisory committee within the definition of 5 U.S.C. App., Section 5(b).

XIV. Changes in Existing Law

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in

italic, existing law in which no change is proposed is shown in roman):

TITLE 5, UNITED STATES CODE

* * * * * * *

CHAPTER 59—ALLOWANCES

* * * * * * *

SUBCHAPTER IV—MISCELLANEOUS ALLOWANCES

* * * * * * *

[*21]

§ 5948. Physicians comparability allowances

(a) Notwithstanding any other provision of law, and in order to recruit and retain highly qualified Government physicians, the head of an agency, subject to the provisions of this section, section 5307, and such regulations as the President or his designee may prescribe, may enter into a service agreement with a Government physician which provides for such physician to complete a specified period of service in such agency in return for an allowance for the duration of such agreement in an amount to be determined by the agency head and specified in the agreement, but not to exceed—

(1) * * *

(2) [$20,000] *$30,000* per annum if the Government physician has served as a Government physician for more than twenty-four months.

For the purpose of determining length of service as a Government physician, service as a physician under section 4104 or 4114 of title 38 or active service as a medical officer in the commissioned corps of the Pub-

lic Health Service under Title II of the Public Health Service Act (42 U.S.C. ch. 6A) shall be deemed service as a Government physician.

* * * * * * *

CHAPTER 89—HEALTH INSURANCE

* * * * * * *

Sec.
8901. Definitions.

* * * * * * *

8903b. Authority to readmit an employee organization plan.

* * * * * * *

§ 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) * * *

* * * * * * *

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee [organization;] *organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;*

§ 8902. Contracting authority

(a) * * *

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical **[*22]** psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

[(2)] *(3)* The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

* * * * * * *

[(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of cover-

age or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.]

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

* * * * * * *

§ 8902a. Debarment and other sanctions

(a)(1) For the purpose of this section—

(A) the term "provider of health care services or supplies" or "provider" means a physician, hospital, or other individual or entity which furnishes health care services or supplies;

(B) the term "individual covered under this chapter" or "covered individual" means an employee, annuitant, family member, or former spouse covered by a health benefits plan described by section 8903 or 8903a; [and]

(C) an individual or entity shall be considered to have been "convicted" of a criminal offense if—

(i) * * *

* * * * * * *

(iv) in the case of an individual, the individual has entered a first offender or other program pursuant to which [*23] a judgment

of conviction for such offense has been withheld;

without regard to the pendency or outcome of any appeal (other than a judgment of acquittal based on innocence) or request for relief on behalf of the individual or entity[.]; and

(D) the term "should know" means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;

(2)(A) Notwithstanding section 8902(j) or any other provision of this chapter, if, under [subsection (b) or (c)] subsection (b), (c), or (d), a provider is barred from participating in the program under this chapter, no payment may be made by a carrier pursuant to any contract under this chapter (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment.

* * * * * * *

(b) [The Office of Personnel Management may bar] *The Office of Personnel Management shall bar* the following providers of health care services or supplies from participating in the program under this chapter:

(1) * * *

* * * * * * *

[(5) Any provider—

[(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the

provider's professional competence professional performance, or financial integrity; or

[(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.]

(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).

(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

(1) Any provider—

(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in sub-

[*24] *section (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.*

(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.

[(c)] (d) Whenever the Office determines—

[(1) in connection with a claim presented under this chapter, that a provider of health care services or supplies—

[(A)has charged for health care services or supplies that the provider knows or should have known were not provided as claimed; or

[(B)has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies;]

(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

(A) an item or service not provided as claimed,

(B) charges in violation of applicable charge limitations under section 8904(b), or

(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);

* * * * * * *

[(d)] (e) The Office— [*25]

(1) * * *

* * * * * * *

[(e)] (f) In making a determination relating to the appropriateness of imposing or the period of any debarment under this section (*where such debarment is not mandatory*), or the appropriateness of imposing or the amount of any civil penalty or assessment under this section, the Office shall take into account—

(1) * * *

* * * * * * *

[(f)(1) The debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as may be specified in regulations prescribed by the Office.]

(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).

* * * * * * *

(3) Any notice of debarment referred to in paragraph (1) shall specify the date as of which debarment becomes effective and the minimum period of

time for which such debarment is to remain effective. *In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).*

(4)(A) A provider barred from participating in the program under this chapter may, after the expiration of the minimum period of debarment referred to in paragraph (3), apply to the Office, in such manner as the Office may by regulation prescribe, for termination of the debarment.

(B) The Office may—

(i) terminate the debarment of a provider, pursuant to an application filed by such provider after the end of the minimum debarment period, if the Office determines, based on the conduct of the applicant, that—

(I) there is no basis under [subsection (b) or (c)] *subsection (b), (c), or (d)* for continuing the debarment; and

[(6) The Office shall, upon written request and payment of a reasonable charge to defray the cost of complying with such request, furnish a current list of any providers barred from participating in the program under this chapter, including the minimum period of time remaining under the terms of each provider's debarment.] **[*26]**

[(g)(1) The Office may not make a determination under subsection (b) or (c) adverse to a provider of health care services or supplies until such provider has been given written notice and an opportunity for a hearing on the record. A provider is entitled to be represented by counsel, to present witnesses, and to

cross-examine witnesses against the provider in any such hearing.

[(2) Notwithstanding section 8912, any person adversely affected by a final decision under paragraph (1) may obtain review of such decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting that the decision be modified or set aside must be filed within 60 days after the date on which such person is notified of such decision.]

(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place

of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.

(3) Matters that were raised or that could have been raised in a hearing under paragraph (1) or an appeal under paragraph (2) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

[(h)] *(i)* A civil action to recover civil monetary penalties or assessments under subsection [(c)] *(d)* shall be brought by the Attor-[*27]ney General in the name of the United States, and may be brought in the United States district court for the district where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered under this section shall be paid to the Office for deposit into the Employees Health Benefits Fund. *The amount of a penalty or assessment as finally de-*

termined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.

[(i)] *(j)* The Office shall prescribe regulations under which, with respect to services or supplies furnished by a debarred provider to a covered individual during the period of such provider's debarment, payment or reimbursement under this chapter may be made, notwithstanding the fact of such debarment, if such individual did not know or could not reasonably be expected to have known of the debarment. In any such instance, the carrier involved shall take appropriate measures to ensure that the individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment.

§ 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) SERVICE BENEFIT PLAN.—One Government-wide plan, *which may be underwritten by participating affiliates licensed in any number of States*, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member,

former spouse, or person having continued coverage under section 8905a of this title.

* * * * * * *

§8903b. Authority to readmit an employee organization plan

(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

(b) A contract for a plan approved under this section shall require the carrier—

(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and **[28]**

(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.

§ 8909. Employees Health Benefits Fund

(a) * * *

* * * * * * *

(e)(1) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term fol-

lowing that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

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[*1]

105TH CONGRESS 2d Session

SENATE

REPORT 105-257

FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1998

JULY 21, 1998.—Ordered to be printed

Mr. THOMPSON, from the Committee on Governmental Affairs, submitted the following

REPORT

[To accompany H.R. 1836]

The Committee on Governmental Affairs, to which was referred the bill (H.R. 1836) to strength the integrity and standards of the Federal Employee Health Benefits Program (FEHBP) and allow it to maintain its reputation as a high quality and cost-effective program, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends, by a vote of 9–0, that the bill as amended do pass.

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I. Summary and Purpose

H.R. 1836, the Federal Employee Health Care Protection Act of 1998, was designed to make a number of improvements to the Federal Employee Health Benefits Program (FEHBP). Specifically, the bill would allow the government to impose sanctions on the providers or bar them from selling coverage to any government agency; would encourage full disclosure in discounted rate agreements; and would establish standards for readmitting discontinued health [*2] plans and for crediting of associated contingency reserves. Additionally, the bill would make a number of technical changes.

II. Legislative History

H.R. 1836 was introduced by Representative Dan Burton (R–IN) on June 10, 1997. The bill was referred to the House Government Reform and Oversight Committee on June 10, 1997 and to the Subcommittee on Civil Service on June 11, 1997. The legislation was marked up, with amendments, by the Subcommittee on October 22, 1997, and by the full Committee on October 31, 1997. No hearings were held, nor written testimony received. The House passed H.R. 1836 by voice vote, under suspension of the rules, on November 4, 1997.

On November 5, 1997, H.R. 1836 was referred to the Senate Committee on Governmental Affairs, and to the Subcommittee on International Security, Proliferation, and Federal Services on November 11, 1997. On March 31, 1998, a majority (8) of the Subcommittee Members approved reporting favorably

H.R. 1836 to the full Committee. No hearings were held, nor testimony received.

The Committee proceeded to consider H.R. 1836 on April 1, 1998. A technical amendment to section 4 was offered by Senator Cochran. The amendment changed certain dates in Section 4 of the bill to recognize that the health plans currently offered to employees by the Federal Reserve and the Federal Deposit Insurance Corporation did not cease to exist in January 1998. Those agencies may now terminate those health plans before January 3, 1999, thereby allowing employees of those agencies to enroll in the Federal Employee Health Benefits Program. The amendment was adopted by voice vote. H.R. 1836, as amended, was considered en bloc with other legislation and was reported favorably to the full Senate by a recorded vote of 9–0. Voting in the affirmative were Senators Akaka, Cleland, Durbin, Glenn, Levin, Cochran, Nickles, Roth, and Thompson.

III. Need for Legislation

H.R. 1836, as amended by the Committee, addresses several areas of operation of the Federal Employees Health Benefits Program. The legislation provides the Office of Personnel Management with additional ways of fighting waste, fraud, and abuse in the program. Thus, OPM will be equipped to deal effectively with health care providers who participate in fraudulent activities affecting the FEHBP. In addition, the legislation permits certain employees of the Federal Deposit Insurance Corporation and the Federal Reserve Board to participate in the FEHBP, establishes statutory requirements regarding the readmitting of health care plans sponsored by employee organizations that have previously discontinued participation in the FEHBP, and increases the max-

imum amount of the physicians' comparability allowance from $20,000 to $30,000. These changes improve the operation of the program to the benefit of program enrollees, carriers, taxpayers and the federal government.

One area of program operation addressed by H.R. 1836 involves the practice of plan carriers contracting with third parties to obtain [*3] discounts from health care providers. The Committee recognizes the important role that Preferred Provider Organizations (PPOs) play in today's health care market. Frequently, the PPOs negotiate discounted rate schedules with health care providers in exchange for certain incentives. The incentives may include an agreement to steer patients to the provider, in the case of so-called "directed PPOs," or they may include financial incentives such as prepayment or prompt payment in the case of so-called "non-directed PPOs." Both directed and non-directed PPOs provide legitimate and valuable benefits to health care providers, carriers, and patients.

Based upon concerns raised to the House Government Reform and Oversight Committee by the American Medical Association and the American Hospital Association that certain payers were taking advantage of discounts to which they were not entitled, the Office of Personnel Management Inspector General was requested to conduct a review ". . . to determine whether silent PPOs were used by FEHBP carriers to capture discounts to which they were not entitled." That report is included in the Additional Views submitted by Senator Thad Cochran, Chairman of the Subcommittee on International Security, Proliferation and Federal Services.

Under this bill, OPM must encourage carriers to seek assurances from any person with whom they contract to obtain discounted rates from providers that the conditions for such discounts are fully disclosed to the providers who grant them. Further, the Committee recognizes the necessity of the existence of contracts between providers and networks, and the benefits that PPO arrangements provide the FEHBP.

IV. Section-by-Section Analysis

SECTION 1. SHORT TITLE

This Act may be cited as the "Federal Employees Health Care Protection Act of 1998".

SECTION 2. DEBARMENT AND OTHER SANCTIONS

Section 2 relates to debarment and other sanctions on health care providers in the Federal Employees Health Benefits Program (FEHBP).

Definitions

Current law.—Defines the terms "provider of health care," "individual covered under this chapter," and "convicted."

H.R. 1836.—Retains these definitions and adds another for "should know,"—"a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required."

Authority to debar

Current law.—The Office of Personnel Management (OPM) has permissive authority to debar, i.e., exclude certain providers of health care services or supplies from participating in the FEHBP.

[*4] *H.R. 1836.*—Retains permissive authority to debar, but adds mandatory authority to debar.

Grounds for debarment

Current law.—OPM may debar any provider that has been convicted, under federal or state law, or a criminal offense—

(1) relating to fraud, corruption, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care service or supply;

(2) relating to neglect or abuse of patients in connection with the delivery of a health care service or supply;

(3) in connection with the interference with or obstruction of an investigation or prosecution of a criminal offense described in (1) or (2); or

(4) relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

OPM also may debar any provider—

(1) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed by a state licensing authority for reasons relating to the provider's professional competence or performance or financial integrity; or

(2) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned competence, performance, or financial integrity.

H.R. 1836.—Changes permissive debarment to mandatory for any provider convicted of criminal matters cited in grounds 1–4 above.

Further, this provision adds an additional ground for mandatory debarment for any provider that currently is suspended or excluded from participation under any program of the federal government involving procurement or no procurement activities.

The section retains the permissive debarment for the above grounds relating to professional licensing.

The section adds four additional grounds for permissive debarment for—

(1) any provider that is an entity directly or indirectly owned, or with a five percent or more controlling interest, by an individual who was convicted of any offense that is a ground for mandatory debarment, against whom a civil monetary penalty has been assessed, or who has been debarred from participating in FEHBP;

(2) any individual who directly or indirectly owns or has a controlling interest in an entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense for which mandatory debarment may be imposed, assessment with a civil penalty, or debarment from participation;

(3) any provider that OPM determines, in connection with claims presented, has charged for health care services or supplies in an amount substantially in excess of the provider's customary charges for such services or supplies (unless OPM finds there is good cause for such a charge) or has charged for health [*5] care services or supplies substantially in excess of the needs of

the covered individual or which are of a quality which fails to meet professionally recognized standards for the services or supplies; or

(4) any provider that OPM determines has committed acts for which a civil penalty may be imposed.

Consequence of debarment

Current law.—No payment may be made by a carrier pursuant to any FEHBP contract to a provider that is barred from participating in the program for any service or supply furnished by the provider during the period of debarment.

H.R. 1836.—No change.

Authority for civil penalties and additional sanctions

Current law.—OPM has permissive authority to impose, in addition to other penalties that may be prescribed by law, and after consulting with the Attorney General, a civil monetary penalty of not more than $10,000 for any item or service involved.

In addition, a provider against whom a civil penalty has been imposed is subject to a mandatory assessment of not more than twice the amount claimed for each item or service.

Moreover, OPM has permissive authority in the same proceeding to bar such provider from participating in FEHBP.

H.R. 1836.—No change.

Grounds for imposing civil penalties and additional sanctions

Current law.—OPM has permissive authority to impose a monetary civil penalty, mandatory authori-

ty to impose an assessment, and permissive authority to debar whenever it determines—

(1) in connection with a claim presented under FEHBP, that a provider of health care services or supplies has charged for health care services or supplies—

(A) that the provider knows or should have known were not provided as claimed; or

(B) in an amount substantially in excess of the provider's customary charges or substantially in excess of the needs of the covered individual or are of a quality that fails to meet professionally recognized standards for such services or supplies;

(2) has knowingly made, or caused to be made, any false statement of a material fact which is reflected in an FEHBP claim; or

(3) has knowingly failed to provide any information to a carrier or to OPM to determine whether a payment or reimbursement is payable under FEHBP or the amount of any such payment or reimbursement.

H.R. 1836.—Amends paragraph (1) above by substituting "claims" in place of "claim," retaining (A), deleting (B), and replacing it with two grounds for any provider that has charged for a health care service or supply which the provider knows or should have known involves—

(B) charges in violation of applicable charge limitations under 5 U.S.C. section 8904(b) relating to Medicare; or **[*6]**

(C) an item or service furnished during a period when the provider was excluded from partic-

ipation in FEHBP pursuant to a determination by OPM, other than as permitted under subsection (g)(2)(B) relating to postponing the effective date of a debarment.

Time limitation on debarment or imposing civil penalties

Current law.—OPM may not initiate any debarment proceeding based on a criminal conviction later than six years after a provider was convicted and may not impose a civil penalty, assessment, or debarment later than six years after the date a claim meriting a civil penalty is presented.

H.R. 1836.—No change.

Factors to be considered in debarment or imposing civil penalties

Current law.—In determining the appropriateness of imposing debarment, a period of debarment, or a civil penalty, OPM is required to take into account—

(1) the nature of any claims involved and the circumstances under which they were presented;

(2) the degree of culpability, history of prior offenses or improper conduct of the provider involved; and

(3) such other matters as justice may require.

H.R. 1836.—Limits consideration of these factors only to cases where debarment is permissive or to civil penalties; it does not require considering them for mandatory debarments.

Effective date of debarment

Current law.—Debarment of a provider under permissive debarment authority or in connection with a civil penalty is effective at such time and upon such reasonable notice to the provider and to carriers and covered individuals as specified by OPM regulations. Debarment is effective for any health care services or supplies furnished by a provider on or after the effective date of debarment, except for inpatient services to an individual who was admitted to the institution before the date of debarment until 30 days after that date, unless OPM determines a shorter period is necessary in order to protect the health or safety of the individual receiving those services.

Any notice of debarment must specify the date the debarment will become effective and the minimum period it will remain in effect.

H.R. 1836.—In most circumstances, under mandatory and permissive debarment authorities, the debarring official has authority to determine the effective date of debarment without regard to a hearing. Any provider may request a hearing after the effective date of debarment. However, in the case of permissive debarments on the grounds that would subject the provider to civil monetary penalties, OPM cannot make a determination which is adverse to a provider until the provider has been given reasonable notice and an opportunity for the determination to be made after a hearing. The hearing must occur before the adverse action is taken, unless OPM determines that the health or safety of individuals receiving health care warrants an earlier date.

[*7] *Period of debarment*

Current law.—Generally, the minimum period as specified by OPM regulation. Existing law does not mandate a minimum period of debarment.

H.R. 1836.—Generally imposes that providers convicted under federal or state law of specified offenses must be debarred for at least three years. Those offenses include:

(1) fraud, corruption, breach of fiduciary responsibility or other financial misconduct;

(2) neglect or abuse of patients;

(3) interference with or obstruction of an investigation or prosecution of a criminal offense described in paragraphs (1) and (2) above;

(4) a criminal offense relating to the manufacture, distribution, prescription, or dispensing of a controlled substance.

Termination of debarment

Current law.—A provider permissively barred from participating in the FEHBP may, *after* the expiration of the minimum period of debarment specified in the notice, apply to OPM for termination of debarment. OPM may terminate the debarment after the end of the minimum debarment period if it determines that there is no basis under the permissive debarment authority or the civil penalty authority for continuing the debarment and there are reasonable assurances that the types of action which formed the basis for the original debarment have not recurred or will not recur.

OPM may terminate the debarment of a provider before the expiration of the minimum debarment pe-

riod if it determines that there is no basis for continuing the debarment, there are reasonable assurances that such behavior has not and will not recur, and early termination is warranted because the provider is the sole community provider or the sole source of essential specialized services in a community.

H.R. 1836.—Authorizes OPM to terminate a mandatory debarment after the minimum debarment period if it determines that there is a no basis under mandatory debarment authority for continuing the debarment.

Notice and hearing requirements and judicial review

Current law.—OPM may not make a determination under permissive debarment authority or civil penalty authority adverse to a provider until after the provider has been given written notice and an opportunity for a hearing, i.e., a pre-adverse action hearing. Any person adversely affected by an OPM final adverse decision may obtain review of the decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting modification or setting aside of OPM's decision must be filed within 60 days after the provider is notified.

H.R. 1836.—Amends this provision by substituting that any provider that is subject of an adverse OPM determination is entitled to reasonable notice and an opportunity to request a hearing of record, i.e. a post-adverse action hearing of record. OPM is required to grant a request for a hearing upon a showing that due process [*8] rights previously have not been afforded for any finding of fact relied upon as a cause for an adverse determination.

Such a hearing is conducted without regard to subchapter II of chapter 5 of title 5, United States

Code, relating to administrative procedure, and chapter 7 of title 5, relating to judicial review. The hearing is conducted by a hearing officer who is appointed by the Director of OPM. A request for a hearing is required to be filed within such a period and in accordance with procedures as prescribed by OPM.

Any provider adversely affected by a final decision made after a hearing may seek review in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his principle place of business by filing an appeal within 60 days from the date the decision is issued.

The court has power to enter, upon the pleadings and record, a judgment affirming, modifying, or setting aside, in whole or in part, OPM's decision, with or without remanding the cause for a hearing. The district court may not set aside or remand an OPM decision unless there is not substantial evidence on the record to support the findings of OPM or unless the action taken by OPM constitutes an abuse of discretion.

Venue of civil penalty actions

Current law.—A civil action to recover civil monetary penalties or assessments must be brought by the Attorney General and may be brought in the district court where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered are paid to OPM for deposit into the Employees Health Benefits Fund.

H.R. 1836.—Retains current law and adds that the amount of a penalty or assessment as determined by OPM, or other amount OPM may agree to in compromise, may be withheld from any sum then or later

owing by the United States to the party against whom the penalty or assessment has been levied.

Effective dates

Current law.—Not applicable.

H.R. 1836.–With three exceptions, the amendments made by H.R. 1836 take effect on the date of enactment.

The first exception relates to permissive debarment under specified circumstances and applies only to the extent that the misconduct which is the basis for the permissive debarment occurs after the date of enactment.

The second exception involves civil monetary penalties and assessments for violations of charge limitation relating to Medicare and applies only for charges for items or services furnished after the date of enactment.

The third exception relates to the minimum three year period of mandatory debarment for grounds prescribed in the mandatory debarment section and applies only with respect to criminal convictions that occur after enactment.

[*9] SECTION 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

Current Law.—Does not specify that an association of organizations may serve as the carrier for any health benefits plan in the FEHBP. It also does not specify that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia.

H.R. 1836.—Amends the definition of "carrier" and the description of the government-wide Service Benefit Plan under current law. Additionally, H.R. 1836 broadens the preemption provisions in current law to enable national plans to offer uniform benefits and rates to enrollees regardless of where they live.

Specifically, section 3 does the following:

Amends paragraph (7) of section 8901, title 5, U.S.C. by striking "organization" and inserting "organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan."

Amends paragraph (1) of section 8903, title 5, U.S.C. by striking "plan" and inserting "plan, which may be underwritten by participating affiliates licensed in any number of States."

Amends section 8902(m) of title 5, U.S.C. by striking "(m)(1) and all that follows through that paragraph, and inserting "(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plan."

SECTION 4. CONSISTENT COVERAGE FOR INDIVIDUALS ENROLLED IN A HEALTH PLAN ADMINISTERED BY THE FEDERAL BANKING AGENCIES

Current law.—Requires that federal retirees must have participated in the FEHBP for at least five years immediately preceding retirement in order to be eligible to participate in the FEHBP as a retiree and for certain continuation of coverage upon separa-

tion from service. In recent years, the Federal Reserve Board, the Federal Deposit Insurance Corporation, the Office of the Comptroller of the Currency, and the Office of Thrift Supervision have sponsored their own health insurance plans for their employees. These agencies are now dropping those plans and participating in the FEHBP. P.L. 103–409 allowed employees of the Office of the Comptroller of the Currency and the Office of Thrift Supervision to participate in the FEHBP if they had been enrolled in their agency's plan before separation in order to meet the five year requirement.

H.R. 1836.—Would deem participation in a health insurance plan sponsored by the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System to meet the enrollment requirements for participation in the FEHBP as retirees or under continuation of coverage conditions. it would require these federal banking agencies to make a payment to the FEHBP fund to cover the government's share of premium costs for retirees who would, by the Act, be made eligible for FEHBP coverage as an annuitant.

[*10] In an amendment adopted by the Committee, the effective dates for the transition in the FEHBP is changed from "on January 3, 1998" to "on or before January 2, 1999" to ensure that the transition in the FEHBP is limited only to those Federal Reserve and FDIC employees who were participating in the health care plans that those agencies are now terminating. In addition, this amendment reflects the fact that the health plans currently offered to employees by the Federal Reserve and the FDIC did not cease to exist in January 1998; and that those agencies may now terminate those health plans any-

time before January 3, 1999 thereby allowing employees to move into the FEHBP.

SECTION 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS

Current law.—Does not have a full disclosure requirement.

H.R. 1836.—Directs OPM to encourage carriers who obtain provider discounts to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SECTION 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP

Current Law.—Does not allow health care plans sponsored by an employee organization to reenter the FEHBP after previously discontinuing its participation. Additionally—with respect to the contingency reserves of the discontinued plans—OPM is required to distribute those reserves to plans continuing in the FEHBP in the contract year after the discontinuance.

H.R. 1836.—Amends chapter 89 of title 5 by adding the following after section 8903(a): 8903(b). Authority to readmit an employee organization plan.

In the event that a plan described by section 8903(3) or 8903a is discontinued (other than in the circumstance described in section 8909(d)), the plan may be reconsidered for FEHBP eligibility for any contract year after the third contract year in which the plan was discontinued.

Subsection (e) of section 8909 of title 5, U.S.C., is amended by striking "(e) and inserting "(e)(1)" and by adding language that requires OPM to distribute the

contingency fund reserves of certain discontinued plans within 2 contract years.

SECTION 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE

Current Law.—In 1978 the Federal Physicians Comparability Act, PL 95–603, was passed and provided a maximum of $10,000 per year in additional compensation for one year of service for physicians where significant recruitment and retention problems exist. In 1987 the maximum physicians comparability allowance (PCA) as increased by Congress to $20,000 per year. These provisions are codified in 5 U.S.C. 5948 and implementing regulations were issued by OPM in 5 C.F.R. 595.

H.R. 1836.—Increases the maximum physicians comparability allowance Federal agencies may pay from $20,000 to $30,000 per year.

[*11] SECTION 8. CLARIFICATION RELATING TO SECTION 8902(K)

Current Law.—Requires carriers offering health benefit plans under the FEHBP to provide for direct payment for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/ clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11).

H.R. 1836.—Amends section 8902(k) of title 5, U.S.C., by inserting after paragraph (1) language ensuring that no health benefits plan is precluded from providing direct access or direct payments for services provided by a health care professional not listed in paragraph (1), as long as the professional is li-

censed or certified as such under Federal or State law.

V. Estimated Cost of Legislation

U.S. Congress,

Congressional Budget Office,

Washington, DC, June 1, 1998.

Hon. Fred D. Thompson,

Chairman, Committee on Governmental Affairs, U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1836, the Federal Employees Health Care Protection Act of 1998.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts for the federal budgetary impact are Tom Bradley (for the Federal Employees Health Benefits program), Mary Maginniss (for the Federal Deposit Insurance Corporation) and John R. Righter (for federal pay), and Mark Booth (for the Federal Reserve). The CBO staff contact for the state and local impact is Leo Lex.

Sincerely,

June E. O'Neil, *Director.*

Enclosure.

Congressional Budget Office Cost Estimate

H.R. 1836—Federal Employees Health Care Protection Act of 1998

Summary: H.R. 1836 would modify the administration of the Federal Employees Health Benefits

(FEHB) program, transfer the health coverage of retirees and certain active employees of the Federal Deposit Insurance Corporation (FDIC) and the Board of Governors of the Federal Reserve to the FEHB program, and raise the pay of certain physicians employed by the federal government. CBO estimates that the legislation would reduce direct spending by $54 million and federal revenues by $7 million over the 1999–2003 period. Consequently, pay-as-you-go procedures would apply to the legislation. In addition, CBO estimates that implementing H.R. 1836 would increase discretionary outlays by $30 million over the 1999–2003 period, assuming appropriation of the necessary amounts.

[*12] H.R. 1836 would expand a preemption of state and local authority to regulate health care plans that provide coverage under FEHB. This preemption would be considered a mandate under the Unfunded Mandates Reform Act (UMRA). However, because the preemption would simply limit the application of state law in some circumstances, CBO estimates that any costs to state or local governments arising from this mandate would be minimal. H.R. 1836 contains no private-sector mandates as defined in UMRA.

Estimated Cost to the Federal Government: The estimated budgetary impact of H.R. 1836 is shown in the following table. This estimate assumes that the legislation will be enacted by the start of fiscal year 1999. The legislation would effect governmental receipts and outlays in several budget functions.

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002	2003
CHANGES IN DIRECT SPENDING						
FDIC:						
Estimated budget authority ...	0	0	0	0	0	0
Estimated outlays	0	160	-14	-15	-18	-20
FEHB:						
Estimated budget authority ...	0	-178	6	7	8	10
Estimated outlays	0	-178	6	7	8	10
Total Changes in Direct Spending:						
Estimated budget authority ...	0	-178	6	7	8	10
Estimated outlays	0	-18	-8	-8	-10	-10
CHANGES IN REVENUES						
FEBH Coverage for Federal Reserve:						
Estimated revenues	0	-11	1	1	1	1

SPENDING SUBJECT TO APPROPRIATION

Spending on Physicians Comparability Allowance Under Current Law:[4]						
Estimated budget authority ...	27	27	27	27	14	0
Estimated outlays	27	27	27	27	14	1
Proposed changes:						
Estimated authorization level ...	0	7	9	9	5	0
Estimated outlays.....	0	7	9	9	5	([5])
Spending on Physicians Comparability Allowance Under H.R. 1836:						
Estimated authorization level ...	27	34	36	36	19	0
Estimated outlays	27	34	36	36	19	1

[4] Under current law, agencies can offer allowances to physicians through fiscal year 2000, with the contracts for such allowances extending through fiscal year 2002.

[5] Less than $500,000.

Basis of estimate: By modifying the health coverage of FDIC and Federal Reserve retirees and active employees within five year of retirement, H.R. 1836 would affect both direct spending (for the FIC and the FEHB program) and revenues (for the Federal Reserve). In addition, increasing the pay of certain physicians employed by the government would affect discretionary spending.

Direct spending and Revenues

Health Insurance Transfer for Certain Employees. H.R. 1836 would transfer the health insurance coverage of retirees and certain active employees of the FDIC and the Board of Governors of the Federal Reserve System to the FEHB program. Currently, those two agencies operate their own health insurance programs. The legislation would also require the two agencies to make a one-[*13]time payment to the Office of Personnel Management (OPM), which administers the FEHB program, to cover the long-term cost of the government's contribution toward the insurance premiums of the newly covered individuals.

The shifting of the FDIC employees and retirees to the FEHB program would reduct direct spending in each year because the FDIC pays more for health insurance than the FEHB program would. The current FDIC plan is more expensive that the typical FEHB plan because the insured employees are older and fewer in number, and it provides more general coverage. Ongoing savings would grow form an estimated $7 million in fiscal year 1999 to $11 million in 2003. CBO assumes that the FDIC would make the required one-time payment to OPM in January 1999. We estimate that the one-time payment would be $170 million; but we also estimate that the FDIC

would save $10 million in the same year from lower health insurance costs. The net cost to the FDIC in 1999, therefore, would be $160 million. Reflecting the transfer from the FDIC, the FEHB program would receive the payment of $170 million in that year but would incur additional costs of about $3 million to insure those employees and retirees, for new savings of $167 million to the FEHB program.

The transfer between the Federal Reserve and the FEHB program would have a similar effect, but significantly fewer employees would be affected at the Federal Reserve. We estimate that the Federal Reserve would make a one-time payment of $12 million to OPM in 1999, with associated savings of $1 million, for a net reduction in revenues of $11 million. The associated savings to the Federal Reserve and costs to the FEHB program beyond 1999 would both approximate $1 million per year, although FEHB costs may be slightly less and the Federal Reserve's savings slightly more. Also, the budgetary effects on the Federal Reserve are re-corded on the revenue side of the budget. Thus, the resulting increases in federal revenues beyond 1999 would approximate the increase in FEHB costs for coverage of Federal Reserve personnel, and the net budgetary impact each year would be negligible.

Other Provisions. CBO estimates that the other provisions of H.R. 1836 would not significantly affect FEHB spending. The legislation would strengthen OPM's ability to bar or sanction unethical health providers and expand a preemption of state and local authority to regulate health plans that provide coverage under FEHB. Enacting those provision might reduce FEHB costs slightly.

H.R. 1836 also would require OPM to encourage carriers to seek assurances that health care providers who contract with third parities to provide discounted rates are made aware of the conditions for those discounts. That provision could discourage some FEHB plans from using certain discount vendors, potentially increasing costs. Based on a survey conducted by OPM, however, FEHB plans believe that their discount vendors disclose the conditions of the discount to health care providers.

Finally, section 8 would allow plans to make direct payments to certain non-physician providers, even when such arrangements are not required by law. Because plans already have such authority, the enactment of that section would not affect FEHB spending.

[*14] *Spending subject to appropriation*

H.R. 1836 would increase the maximum annual allowance payable to eligible federal physicians to $30,000. Current law authorizes certain agencies to pay allowances of up to $20,000 a year to recruit and retain physicians for certain positions, such as those with long-term vacancies or high turnover rates. To receive the allowance, physicians must agree to work at least one year at the agency. CBO estimates that increasing the maximum annual allowance from $20,000 to $30,000 would increase salary costs by $30 million over the 1999–2003 period. This estimate is based on information provided by OPM, including data on the number of federal physicians receiving comparability allowances and the average annual premium that they receive under current service agreements. CBO estimates that the provision would increase the average allowance for 1,800 physicians by about $5,000 a year and that agencies

would modify service agreements with physicians within the few months of fiscal year 1999.

The authority for agencies to offer allowances to physicians was extended through fiscal year 2000 by the Treasury and General Government Appropriations Act for fiscal year 1998 (Public Law 105–61). Under that authority, agencies and physicians can enter into contracts that extend through the end of fiscal year 2002. Most service agreements are made for two years. CBO assumes that the number of outstanding contracts in fiscal year 2001 will approximate the number of contracts in 2000, and that the number of contracts in fiscal year 2002 will be about one-half of the number estimated for 2001. Thus, the increase in costs for fiscal year 2002 is lower than for previous years.

Pay-as-you-go consideration: The Balances Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governments receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

The budget excludes from pay-as-you-go calculations expenses associated with maintaining the deposit insurance commitment. CBO assumes that the increase in costs to the FEHB program and the decreases to the FDIC from its employees joining the FEHB plan would be excluded from the pay-as-you-go calculations because they would be associated with maintaining the deposit insurance commitment. The budgetary effects on the Federal Reserve, and

the corresponding effect on outlays of the FEHB program, would not be excluded.

[By fiscal year, in millions of dollars]

	19-98	19-99	20-00	20-01	20-02	20-03	20-04	20-05	20 06	20-07	20-08
Changes in outlays	0	–11	1	1	1	1	1	1	1	1	1
Changes in receipts	0	–11	1	1	1	1	1	1	1	1	1

Estimated impact on state, local, and tribal governments: H.R. 1836 would add language expanding the preemption of state and local authority to regulate health care plans that provide coverage [*15] under the FEHB program. Current law prohibits state and local governments from regulating the nature and extent of coverage and benefits for people covered by the FEHB program if the regulation of law is inconsistent with the contract provisions. The new language would preclude state and local governments from regulating the provision of coverage or benefits as well, and it removers the language dealing with inconsistencies, thereby giving the federal contract provisions clear authority. These changes would affect states that have requirements governing what types of organization can provide health care when those requirements are different from those under federal contracts. This preemption would be considered a mandate under UMRA. However, because the only effect of the preemption would be to limit the application of state law in some cir-

cumstances, CBO estimates that any costs to state or local governments arising from this mandate would be minimal.

Estimated impact on the private sector: H.R. 1836 contains no private-sector mandates as defined in UMRA.

Previous CBO estimate: On November 3, 1997, CBO prepared a cost estimate for H.R. 1836, as ordered reported by the House Committee on Government Reform and Oversight on October 31, 1997. For the House version of H.R. 1836, CBO did not estimate any effect on direct spending or governmental receipts. This estimate corrects that error.

Estimate prepared by: Federal Costs: Tom Bradley, FEHB, Mary Maginniss, FDIC, Mark Booth, Federal Reserve, and John R. Righter, federal pay.

Impact on State, local, and Tribal governments: Leo Lex. Estimate approved by: Robert A. Sunshine, Deputy Assistant Director for Budget Analysis.

VI. Evaluation of Regulatory Impact

Pursuant to the requirement of paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee has considered the regulatory and paperwork impact of H.R. 1836. The Committee reports that section only 3 of H.R. 1836, making technical changes regarding national plans, would result in a mandate, but costs to state and local government have been estimated by CBO to be minimal. Provisions of the bill relating to health insurance [section 3(c)] would preempt all State and local laws that relate to health insurance or plans. Section 2 of H.R. 1836 should reduce administrative burdens on the Office of Personnel Management by streamlining the debarment process. In general, OPM would be

permitted to debar a provider prior to a hearing being held. Section 4 of H.R. 1836 would reduce the administrative burdens on both the Federal Reserve and the FDIC by enabling them to avoid maintenance of a non FEBH program plan for Federal Reserve and FDIC employees currently ineligible for FEHBP coverage. Under H.R. 1836, these ineligible individuals will be offered FEHBP coverage at no cost to the Federal government. [*16]

VII. Additional Views of Senators Cochran, Glenn, and Levin

At the request of the House Subcommittee on Civil Service, the Office of Personnel Management Inspector General (OPM IG) conducted a study to determine whether silent Preferred Provider Organizations (PPOs) were used by Federal Employee Health Benefit Plan (FEHBP) carriers to capture discounts to which they were not entitled. In brief, the IG found no evidence that health care providers were being victimized by FEHBP carriers, nor any evidence of schemes allowing payers to capture discounts they are not contractually entitled to receive. Although we support inclusion in H.R. 1836 of section 5 bill language, we believe Congress should be careful to avoid interjecting the federal government into contractual issues between health care providers and health plans.

A recent audit by the OPM IG defined "Silent" PPOs as a health care provider discount taken by a FEHBP carrier without a contract existing between the PPO and the health care provider. This is the type of unethical practice that the FEHBP carriers should avoid.

Further, PPOs, both directed and non-directed, provide various incentives to health care providers which contract with PPOs for the benefit of FEHBP, i.e., to re duce health care costs. The FEHBP must continue to benefit from these relationships, recognizing that the PPOs must always have a contract with the health care provider.

Attached is the February 26, 1998 report of the OPM IG, as submitted to Congress, by Patrick E. McFarland, Inspector General, Office of Personnel Management.

CARL LEVIN.
JOHN GLENN.
THAD COCHRAN.

[*17] OFFICE OF PERSONNEL MANAGEMENT,
Washington, DC, February 26, 1998.

Hon. THAD COCHRAN,

Chairman, Subcommittee on International Security, Proliferation and Federal Services, Senate Committee on Governmental Affairs, Washington, DC.

DEAR CHAIRMAN COCHRAN: As a result of interest initially expressed by Chairman Mica, House Subcommittee on Civil Service, Committee on Government Reform and Oversight, the Office of Personnel Management (OPM), Office of the Inspector General (OIG) has performed a review of the use of "silent" and "non-directed" Preferred Providers Organizations (PPOs) in the Federal Employees Health Benefits Program (FEHBP). Our report is enclosed. The committee expressed the concerns of the American Hospital Association and American Medical Association who suggested that health care providers are being victimized by schemes that create payment discounts for payers who are not entitled to them.

These schemes are purportedly carried out by "silent PPOs." Thus, the principal purpose of our review was to determine whether "silent PPOs" were used by FEHBP carriers to capture discounts to which they were not entitled. Our review did not disclose any evidence that FEHBP carriers used "silent PPOs" to capture discounts or that health care providers were otherwise victimized by FEHBP carriers. Nevertheless, we observed that for 1.3 percent of the claims we tested, discounts taken were inconsistent with agreed upon contract terms. We do not consider these errors to be material nor are they indicative of a systemic problem.

At the request of the committee, we also determined how wording in OPM's annual carrier call letter, which encouraged carriers to seek discounts on providers' bills, came to be included in the call letter. We found that the wording was included as a result of discussions between House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A copy of this report has been sent to Representative Dan Burton, Chairman, Committee on Government Reform and Oversight. If you need any additional information related to this review, please call me, or have a member of your staff call Harvey D. Thorp, Assistant Inspector General for Audits.

Sincerely,

PATRICK E. MCFARLAND, *Inspector General.*

Enclosure.

[*18]

REPORT OF REVIEW

OFFICE OF THE INSPECTOR GENERAL
OFFICE OF PERSONNEL MANAGEMENT

REPORT ON THE USE OF SILENT PPOs
IN THE
FEDERAL EMPLOYEES HEALTH BENEFITS
PROGRAM

REPORT NUMBER 99-00-97-054
DATE February 26, 1998

s/
Harvey D. Thorp
Assistant Inspector General for
Audits

-- CAUTION --

This audit report may contain proprietary data which is protected by Federal law (18 USC 1905); therefore, while this report is available under the Freedom of Information Act, caution should be exercised before releasing the report to the public.

[*19]

Report Number 99-00-97-054

OFFICE OF THE INSPECTOR GENERAL
OFFICE OF PERSONNEL MANAGEMENT

REPORT ON THE USE OF SILENT PPOs IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

I. INTRODUCTION AND SUMMARY OF RESULTS

As a result of interest initially expressed by Chairman Mica, House Subcommittee on Civil Service, Committee on Government Reform and Oversight, the Office of Personnel Management (OPM), Office of the Inspector General (OIG) has performed a review of the use of "silent" and "non-directed" Preferred Providers Organizations (PPOs) in the Federal Employees Health Benefits Program (FEHBP). The committee expressed the concerns of the American Hospital Association and American Medical Association who suggested that health care providers are being victimized by schemes that create payment discounts for payers who are not entitled to them. These schemes are purportedly carried out by "silent PPOs." Thus, the principal purpose of our review was to determine whether "silent PPOs" were used by FEHBP carriers to capture discounts to which they were not entitled. Our review did not disclose any evidence that FEHBP carriers used "silent PPOs" to capture discounts or that health care providers were otherwise victimized by FEHBP carriers. Nevertheless, we observed that for 1.3 percent of the claims we tested, discounts taken were inconsistent with

agreed upon contract terms. We do not consider these errors to be material nor are they indicative of a systemic problem.

At the committee's request, we also determined how wording in OPM's annual carrier call letter, which encouraged carriers to seek discounts on providers' bills, came to be included in the call letter. We found that the wording was included as a result of discussions between the House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A detailed discussion of our review objectives, scope, and methodology is presented in Section IV. Substantive comments made in response to a draft of this report from several affected parties are included in the appendix.

II. BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86 382), enacted on September 28, 1959. The FEHBP was created to provide health insurance [*20] benefits for federal employees, annuitants, dependents, and others. OPM's Retirement and Insurance Service has overall responsibility for administration of the FEHBP. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers that provide either service benefits, indemnity benefits, or comprehensive medical services. Health insurance carriers provide these benefits on either a fee-for-service or a prepaid basis. For

calendar year 1997, there were 14 fee-for-service plans and about 460 prepaid plans in the FEHBP. In a fee-for-service plan, the medical provider is paid a fee for the specific service provided. The size of the fee will vary depending on the complexity of the service. The subscriber's group insurance premiums reflect the composite cost of all fees paid to medical providers on behalf of all subscribers in the group. In a prepaid plan, the providers are generally paid a fixed amount which is intended to cover all the services required by individual subscribers. Because of the fixed nature of the payment, the providers are at risk of not recovering all their costs. This risk is an incentive for prepaid plans to control their costs.

During the last decade, the health insurance industry has been undergoing rapid change in response to rising costs. The rapid growth of prepaid health carriers, generally referred to as Health Maintenance Organizations (HMO), who, through their ability to better control costs via utilization control and managed care techniques, have caused fee-for-service carriers to seek better ways and means to control their costs so that they can remain competitive. One cost control method used by fee-for-service carriers is known as a Preferred Provider Organization (PPO). A PPO is a group of medical providers who agree to provide medical services to the subscribers of an insurance carrier at a lesser cost than would have been otherwise charged. The perception is that in a traditional PPO, the PPO would employ some method of controlling benefit utilization by subscribers and would manage medical care more cost effectively. They might also establish controls to improve the quality of care. In exchange for a preferred status, lower fees, and better care, the carrier would attempt to steer its subscribers to the PPO's medical provid-

ers through such methods as financial incentives, ID cards, and preferred provider lists. Thus, significant savings could be achieved by the carrier which would reduce its premium costs.

In recent years, a new variation of the PPO concept appeared. This variation is known as a "non-directed" PPO as distinguished from the traditional PPO which has become known as a "directed" PPO. The terms "directed" and "non-directed" are references to the steerage or lack of steerage of patients. As explained above, in a traditional directed PPO arrangement, subscribers are steered to the PPO to take advantage of the lower costs. In a "non-directed" PPO, even though the medical providers have agreed to charge a lower fee, the contract the PPOs enter into do not require that the carrier's subscribers be steered to them. In some non-directed PPOs, the PPO may benefit from this arrangement as a result of prompt payments or advances. In other non-directed PPO arrangements, the benefits to the provider may be less clear.

In the case of both the directed and non-directed PPOs, the terms of the arrangement are committed to a contract between the parties. Also, there may be intermediate organizational [*21] layers between the insurance carrier and the providers of medical service. In a typical non-directed arrangement in the FEHBP, an insurance carrier contracts with a third party vendor for non-directed PPO services. The vendor assembles the network of non-directed PPO providers by either contracting directly with individual medical providers or by contracting with networks of medical providers who in turn contract with individual medical providers (Exhibit 1). Very frequently, the vendors and the provider networks also

contract with other carriers for directed PPOs. Therefore, non-directed PPO services may be provided to FEHBP carriers while directed PPO services may be provided by the same provider or provider network to non-FEHBP insurance carriers.

Concurrent with the evolution of non-directed PPOs, a new term, "silent PPO" became commonplace. The term, "silent PPO," means different things to different people. Initially, the term "silent PPO" was merely a reference to a non-directed PPO where the contract was "silent" with regard to the steerage of patients to the provider's facilities. However, in more recent times, the term has acquired a more restrictive meaning. As a result, to some people, "silent PPO" describes a payment scheme used to obtain illegal discounts for payers who are not entitled to them. In discussions with interested parties and in industry literature, the terms "fraud," "illicit," "manipulation," "falsely," "unethical," and "scheme" are frequently used to describe silent PPOs. Consequently, the term "silent PPO" has come to mean an unethical and/or illegal practice, and the term has been loosely extended to inappropriately encompass non-directed PPOs. For the purpose of our review, we have differentiated between the terms "non-directed PPO" and the more restrictive term "silent PPO." Since "silent PPO" activity would be inappropriate for the FEHBP, we were concerned with the implication that it may exist in the FEHBP.

A "silent" PPO is distinguished from a "non-directed" PPO by the nature of the contractual relationship between the parties. As stated above, in a "non-directed" relationship, discounts are taken pursuant to contractual arrangements that can be traced from the payer (i.e., the insurance carrier) to

the medical provider. In a "silent PPO," a contractual relationship can not be traced from the payer to the medical provider from whom the discount is taken. Typically, in a silent PPO arrangement, another PPO will sell its medical provider's names and discounted fee information, often without the provider's knowledge and permission, to a secondary market of vendors. These vendors then access the information on behalf of their payer clients, recalculating the provider's fee based on the discounted fee information. It has been alleged that sometimes, the payer may claim a non-existent affiliation with the provider by inaccurately declaring that the patient is a member of a PPO to which the provider is a member.

In 1993, when the distinction between a non-directed PPO and a silent PPO was less clear, OPM became aware of market place arrangements that resulted in the capturing of discounts from provider bills. As a result, in its March 1993 call letter to FEHBP carriers providing rate and benefits instructions for the 1994 contract year, OPM stated, "In addition, OPM is aware that price concessions are available from non-network providers, e.g., hospitals, so carriers are expected to obtain the lowest price available for all goods and services, including non-PPO [*22] providers." The committee is concerned that this OPM requirement may have encouraged the use of improper payment discounts thereby causing an FEHBP provider to grant a discount to a payer that it is not contractually obligated to give.

III. DISCUSSION OF RESULTS

Our review disclosed that substantial savings have been and can be achieved by both directed and non-directed PPOs. We further found these saving

can be achieved in an ethical manner; in that, we found no evidence in the FEHBP that "silent PPOs" were a factor or that provider discounts were otherwise taken on the basis of any schemes to victimize medical providers. In addition, we found FEHBP carriers and their vendors were, except for some minor exceptions, accessing discounts in accordance with the terms of their contracts with providers. Based upon the aggregate of our observations, we believe given the complex environment in which PPOs operate, it is understandable why the expectations for patient steerage by medical providers is not always fulfilled. With regard to OPM's call letter, we found that language which encouraged carriers to seek discounts on providers' bills was the result of discussions between the House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A. Substantial Savings Can Be Achieved through both Directed and Non-directed Preferred Provider Arrangements

As we indicated earlier, a principal reason why carriers enter into preferred provider arrangements is to reduce their costs. Lower costs translate into lower premiums for the FEHBP, the federal government, and its employees. In our survey of FEHBP carriers, we asked carriers how much the FEHBP saved by using directed and non-directed PPOs. Carriers reported substantial savings (See Exhibit 3). The great majority of the savings were realized under directed PPO arrangements. For the six-month period ending June 30, 1997, six carriers reported gross directed PPO savings totaling $390.5 million. This represents 19.7 percent of premiums for those carriers. For the same period, a different

mix of six carriers reported gross non-directed PPO savings totaling $25.5 million representing 2.2 percent of premiums. We conclude that substantial sums can be saved through directed and non-directed PPO arrangements. In view of the fact that directed PPOs provide for steerage of patients, as would be expected, directed PPO savings are significantly larger than non-directed PPO savings. While non-directed PPO savings are substantially lower than directed PPO savings, in absolute terms, they too are significant and offer additional opportunities to reduce FEHBP costs that should not be overlooked, assuming they can be achieved in an ethical and lawful manner.

B. No Evidence Found to Confirm the Use of Payment Schemes that Victimize Health Care Providers in the FEHBP.

Based on our test of insurance benefits paid in August 1997 by FEHBP carriers, we found no evidence that "silent PPOs" were used as a method of capturing discounts or that providers were [*23] being otherwise victimized.

The Committee on Government Reform and Oversight has expressed the concern that medical providers are perhaps being victimized by an alleged practice which accesses provider discounts using subterfuge or misrepresentation. As explained previously, this practice involves the selling of provider names, and the discounts they provide to their directed PPO clients, to third parties who access the discounts by misrepresenting their subscribers as members of the provider's directed PPO. This report uses the term "silent PPO" to describe this practice. In these cases, there is no contractual relationship between the payer of insurance benefits (or their

subcontractors) and the medical providers who are providing the medical services to the payer's subscribers. Such misrepresentation, in our opinion, would constitute, at the very least, an unethical practice in the FEHBP. OPM regulations set forth the minimum standards for health benefit carriers. The standards provide that carriers must perform the contract in accordance with prudent business practices which include, "Legal and ethical business and health care practices." (48 CFR 1609.70(b)(2)). Failure to adhere to minimum standards could be cause for terminating a carrier contract. Consequently, the principal focus of our review was to determine whether any FEHBP carriers, or their subcontractors on behalf of FEHBP carriers, participated in the above described practice.

As explained in the background section, the terms "non-directed PPO" and "silent PPO" have been used interchangeably. Therefore, it was generally thought that those vendors who offer non-directed PPOs also made use of "silent PPOs." Consequently, to search for the use of silent PPOs in the FEHBP, we focused our attention on the vendors who subcontract with FEHBP carriers to provide non-directed PPO services. As a result, we identified five FEHBP carriers who contracted with four (as a result of an acquisition, to become three) vendors to provide non-directed PPO services (See Exhibit 2). [Note: These same vendors may also provide directed PPO services to other clients.] We sampled and reviewed 600 claim lines representing 120 claim lines for each carrier that were repriced by these vendors. The purpose of our sample was to determine whether the discount taken on each claim was pursuant to the medical providers membership in the non-directed PPO and was otherwise consistent with

their contract. We found that in each instance, a series of contractual agreements were in place. These agreements were between the carrier and the vendor, the vendor and provider network or the provider, and the provider network and providers. Consequently, we found no evidence that the FEHBP carriers through their vendors used "silent PPOs" to access discounts.

C. With Minor Exception, Discounts Were Accessed in Accordance with Contract Terms

In addition to ensuring that there was a contractual relationship between all the parties who participated in arranging for the discounts from non-directed PPOs, we also verified that discounts taken were consistent with the contract terms. While the great majority of the claim lines tested were processed in accordance with contract terms, we observed in a few instances, that the FEHBP carrier was not entitled to the discounts taken. We found that the vendors accessed provider discounts in 8 of the 600 claim lines (or 1.3%) that were inconsistent with [*24] contract terms. These improperly taken discounts totaled $675.27 representing 1.24 percent of the $54,370 of discounts taken in our August 1997 sample of 600 claim lines. If our findings for the month of August 1997, were representative of the six-month period ending June 30, 1997, then out of carrier reported non-directed PPO savings of $25.4 million, about $315 thousand was improperly taken. In each case, to access the discount, the contract between either the vendor and provider network or between the provider network and the provider required the steerage of the patient to the provider through some form of financial incentive. In each case, the patient was not steered to the provider in

accordance with the contract terms. Our review at each vendor is further discussed below:

National Preferred Providers Network (NPPN), Inc.

The NPPN is located in Middletown, New York and offers provider networks to its clients. Its network consists of 3,000 hospitals, 18,000 ancillary facilities, and 280,000 physicians. The NPPN contracts with the National Association of Letter Carriers Health Benefit Plan (NALC) to provide a non-directed PPO network. Their agreement provides that NALC is under no obligation to notify participants of the availability of NPPN's network providers.

During our review of the NPPN claim line sample (60 claim lines out of a universe of 33,848), we determined that there were contractual agreements in place that made the medical providers members of NPPN's network. However, we found that NPPN extended some discounts to NALC that we determined were improper. NPPN's contract with one provider network required steerage in order for the discounts to be given to the insurance carrier. This contract covered three claim lines or 5 percent of the claim lines reviewed in our NPPN sample (See Exhibit 4). For the three claim lines, $55.77 in discounts were taken.

Multiplan

Multiplan is located in New York, New York. It is a facility-based preferred provider organization with a network of over 30,000 hospitals and other facilities located throughout the United States. Multiplan contracts with the NALC to provide a non-directed PPO network. Multiplan also provides di-

rected PPO services to other clients. (See appendix for Multiplan comments.)

During our review of the Multiplan claim line sample (30 claim lines out of 6,081), we determined that there were contractual agreements in place that made the medical providers members of Multiplan's network. Generally, we also found that Multiplan agreements with provider networks did not require the steerage of patients, but instead required Multiplan to use its best efforts to encourage appropriate incentives to the Providers. However, we found that Multiplan extended an immaterial discount to NALC from one provider network that we determined was improper (See Exhibit 4). Multiplan's contract with one network required steerage in order for the discounts to be given to the insurance carrier. The contract covered one claim line or 3.33 percent of the lines reviewed. The discount totaled $1.87.

[*25] *United Payors & United Providers (UP & UP)*

The UP & UP is located in Rockville, Maryland. UP & UP provides non-directed PPO services to the following five FEHBP carriers: Foreign Service, APWU, NALC, Rural Carriers, and SAMBA. In September 1997, UP & UP acquired America's Health Plan, Inc.. AHP previously provided non-directed PPO services to FEHBP carriers. (See appendix for UP & UP comments.)

During our review of the UP & UP claim line sample (510 claim lines out of 40,704), we determined that there were contractual agreements in place that made the medical providers members of UP & UP's network. We observed that UP & UP periodically provides its provider networks with a list of client payers. They also provide their hospitals

with a cash prepayment. We also noted that UP & UP agreements state that it will use its best efforts to require each payer client to create financial incentives for covered persons to utilize their providers.

Our review disclosed that UP & UP accessed discounts for four APWU claims that we determined were improper (See Exhibit 4). For the four APWU claim lines, one contract between a provider network and its providers required steerage of subscribers through financial incentives in order for the discounts to be given to the insurance carrier. In all four cases, the carrier did not provide the financial incentives required by the contract. In three of the four cases, the APWU paid 100 percent of the claim. Had co-insurance been applicable to these specific claims, the cost sharing provision of UP & UP's contract with its providers would have been operative thereby authorizing the discounts taken. These four claim lines represent less than one percent of the claim lines reviewed in our sample. The discounts taken total $617.63.

Conclusion

While we found no evidence that silent PPO's were a problem in the FEHBP, we noted that in eight instances, FEHBP carriers were given access to discounts by their vendors to which they were not entitled. In these instances, the contracts with either the provider networks or the providers required a financial incentive to steer patients to the provider's facilities and the subscribers were not so steered. We believe it is the obligation of the vendor to ensure that it does not give FEHBP carriers access to discounts to which they are not entitled. To the extent that these circumstances exist, providers would have

cause for concern. However, the number of instances in our sample were not material.

While the evidence of our review suggests little cause for concern, this conclusion is inconsistent with the level of concern expressed by the medical community. While we found that in the great majority of the cases, discounts taken were consistent with the contract terms, the complex environment and sometimes vague contract terms under which PPOs operate leave expectations on the part of providers that perhaps are not being fulfilled. First, we observed that many of the vendor contracts with provider networks and providers state that the vendor will make a reasonable or best effort to encourage payers to provide incentives to its subscribers to use the vendor's providers. Best efforts do not always translate into actual steerage. Second, the **[*26]** contractual relationship between the vendor and the provider sometimes also involves an intermediary, a regional provider network. These regional network agreements insulate the provider from the true nature of the agreement that exist between the regional networks and the vendor. Third, some payer clients use the vendors for directed PPO services and thus share the same providers with other payer clients who use the vendor's non-directed PPO services. Since the vendor may have only a single contractual agreement with the provider, some of the patients are steered and others are not. Thus, we can visualize how these three factors can combine to cause perhaps false expectations and confusion on the part of providers who may be expecting steerage but in fact entered into an agreement that does not require steerage. We would suggest that the best solution to these factors is education within the industry. We have observed that both the American Medical Asso-

ciation and the American Hospital Association have already begun such an effort.

D. Use of Non-directed PPOs Encouraged by Appropriation Committees

Our review determined that language in OPM's annual carrier call letters, which encouraged carriers to seek discounts on providers' bills, was a result of discussions between House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

Each spring, OPM issues its annual carrier call letter to health benefits carriers. The call letter is a solicitation to current FEHBP carriers for proposed rate and benefit changes for the upcoming contract year which begins January 1. The letter generally provides overall direction and sets the parameters for acceptable rate and benefit changes. Recognizing that in the market place, price concessions were available from non-network providers (meaning providers who do not belong to directed PPO networks), the March 1993 call letter for the 1994 contract year included a new provision which encouraged carriers to obtain price concessions from providers including non-PPO providers (again meaning providers who do not belong to directed PPO networks). The provision read as follows:

> "Carriers are to actively establish or promote the expansion of existing PPO arrangements in terms of availability to enrollees as well as coverage provided. In addition, OPM is aware that price concessions are available from non-network providers, e.g. hospitals, so carriers are expected to obtain the lowest price available for all goods and services, in-

cluding non-PPO providers." (Underline added)

A similar provision was included in the March 1994 call letter for contract year 1995. It read as follows:

> "We continue to encourage expansion of PPO arrangements, in terms of availability of PPO providers to enrollees and coverage provided. In addition, carriers are expected to obtain the lowest price available for all goods and [*27] services, including those of non-PPO providers. All carriers must put in place procedures to capture discounts from all bills presented and/or contract with vendors to do this." (Underline added)

The call letters for contract years 1996, 1997, and 1998 continued to encourage carriers to expand and strengthen their existing PPO arrangements and the services provided under such arrangements. In addition, they each contained the following pertinent provision:

> "We also expect carriers to put in place procedures to capture discounts from bills presented, where cost effective to do so."

The committee was concerned that the call letter language may have encouraged, perhaps inadvertently, the use of improper payment discounts. By "improper," they meant any system of payment discounts for payers who are not entitled to such discounts. They believed that the result of any such improper discount would be to cause an FEHBP provider to grant a discount to a payer that it is not contractually obligated to give. The committee was also concerned that the call letter seems to have had the

effect--intended or not—of spawning efforts on the part of some network managers and/or brokers to require the use of non-directed PPOs by statute. As a consequence, the committee asked us to determine what prompted the language in the OPM call letter.

The former Associate Director for Retirement and Insurance recollected that in 1993 the House Appropriation Committee was considering either report or statutory language which would require FEHBP carriers to take advantage of provider discounts available in the market place. The former Associate Director indicated that he opposed any language which would regulate the market place. Consequently, as a compromise he agreed to include language in OPM's call letter which would encourage FEHBP carriers to take advantage of whatever discount arrangements were available in the market place. In 1993 (for the FY 1994 appropriation) and again in 1994 (for the FY 1995 appropriation), both the House and Senate Appropriation Committee reports on OPM's appropriation bill applauded OPM's action. The House report for the FY 1994 appropriation stated:

> "The Committee feels that, in addition to the cost savings obtained by HMO's and PPO's, all FEHBP carriers should endeavor to obtain the lowest price available for the goods and services they provide. The Committee has learned that while price concessions are available from most providers, not all FEHBP carriers are receiving such discounts. Many carriers in the FEHBP merely pay the billed charges or the usual and customary rate.

> The Committee is aware, however, that some carriers are utilizing large discount networks that have negotiated more favorable rates with providers. The Committee feels there could be significant savings realized through a more concerted effort by carriers to pay the lowest price available for billed medical [*28] charges, and applauds the Office of Personnel Management's reference to such potential efforts in its Letter to Carriers dated March 31, 1993. The Committee believes these efforts should in no way disrupt benefits or attempt to direct patients if they choose not to be directed to specific providers."

Based on our interview with the former Associate Director for Retirement and Insurance and our review of the Appropriation Committees' Report for the Treasury, Postal Service, and General Government Appropriation bills for 1994 through 1995, we conclude that the call letter language was prompted by the House Appropriation Committee.

IV. OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of our review was to determine whether FEHBP carriers were taking advantage of health care providers by using payment schemes that create payment discounts for payers who are not entitled to them. In performing our review, the committee staff requested that we also:

1. Identify organizations that contract with FEHBP carriers to reprice provider bills to obtain a discount where the FEHBP carrier does not have a directed PPO with the provider or the patient has not been given a financial incentive

to use the provider from whom the discount was obtained.

2. Determine whether any discounts were taken by FEHBP carriers to which they were not contractually entitled.

3. Identify providers that have a contract with vendors based solely on the possibility of becoming a part of that vendors network.

4. Identify providers that have a contract with a vendor based solely on the concern that they need to do this to remain competitive.

5. Determine what prompted the language in the OPM call letter to encourage the use of non-directed PPOs by FEHBP carriers.

Our review was performed in accordance with generally accepted government auditing standards for performance audits. The review was performed at the Government Employees Hospital Association, Kansas City, Missouri; United Payors and United Providers, Rockville, Maryland; Multiplan, New York, New York; and National Preferred Providers Network, Middletown, New York during the period June 1997 through December 1997. Additional work was performed in our offices in Washington DC. Our review entailed the following review procedures:

- We conducted an initial review at the FEHBP's Government Employees Hospital Association (GEHA) plan to gain an understanding of the subject. We interviewed carrier officials and traced 34 claims, which were repriced by non-directed PPO vendors, [*29] to contractual

agreements between the GEHA, vendors, and providers. We found no evidence of questionable conduct or contract inconsistencies; that is, in each case, we found that contracts were in place and that discounts were taken pursuant to the contract terms.

- We surveyed 9 of 14 FEHBP fee-for-service carriers to identify which carriers used directed and non-directed PPOs and to identify the non-directed PPO vendors used by the carriers. We did not survey: Blue Cross Blue Shield (has its own PPO networks), GEHA (covered in survey work), Association Benefit Plan (requires extraordinary security procedures), Panama Canal Area Benefit Plan (out of country), and Secret Service (underwritten by BCBS who has its own PPO networks).
- Of the nine carriers surveyed, we found that five carriers used non-directed PPO arrangements. They were:

    1. American Foreign Service Protective Association (Foreign Service),
    2. American Postal Workers Union Health Plan (APWU),
    3. National Association of Letter Carriers Health Benefit Plan (NALC),
    4. Rural Carriers Benefit Plan (Rural Carriers), and
    5. Special Agents Mutual Benefit Association (SAMBA).

We identified four vendors that provided non-directed PPO services to the five carriers (See Exhibit 2). They were:

1. United Payors and United Providers (Up & Up), Rockville, Maryland,
2. America's Health Plan (AHP), Rockville, Maryland (Acquired by UP & UP),
3. Multiplan, New York, New York, and
4. National Preferred Provider Network (NPPN), Middletown, New York.

- From each carrier, we acquired a computer tape of all benefit payments during August 1997. From these tapes, we extracted 80,633 claim lines representing $2.7 million in discounts paid by the five carriers and repriced by one of the four non-directed PPO vendors.
- From the extracted claim lines, we sampled 600 claim lines (120 per carrier) representing $54 thousand in discounts.
- For each of the 600 claim lines, we reviewed the carrier's Explanation of Benefits, when available, traced claims to carrier contracts with vendors and further traced claims to vendor contracts with provider networks and/or providers.
- We reviewed the carrier and provider network contracts at the vendors' offices to determine whether contracts were in place and to determine whether the contracts [*30] required steerage in order to access the discounts. When present in the vendors file, we also examined the provider network's contracts with providers to determine whether steerage was required.
- We recalculated a sample of discounts to verify that discounts were calculated consistent with contract terms.

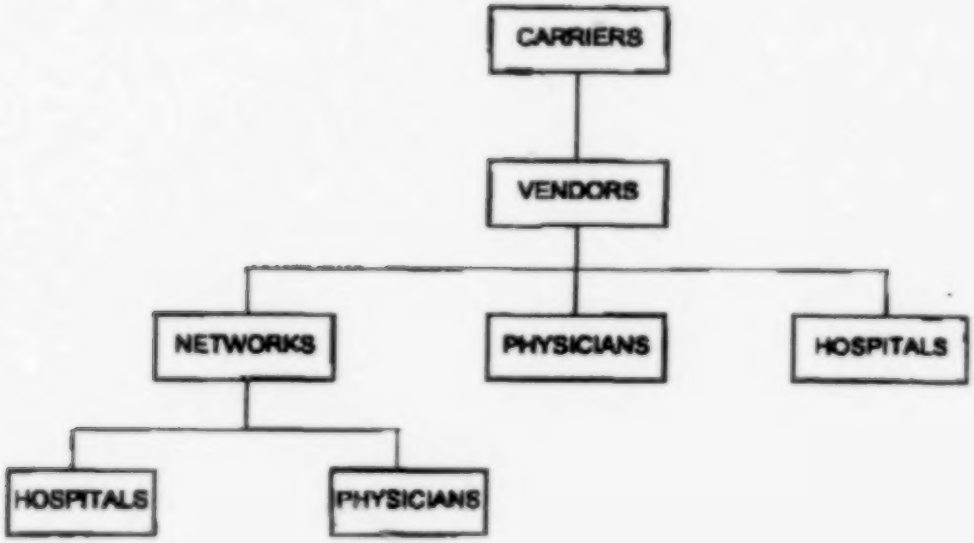
- We met with representatives from the American Medical Association and the Federation of American Health Systems.
- We did a literature search and reviewed the articles identified.
- We surveyed 30 hospitals that complained to OPM about its call letter provision regarding the capture of discounts.
- With regard to the call letter issue, we reviewed OPM's call letter files for the period 1991 through 1997 and interviewed both the former Deputy and Associate Directors for Retirement and Insurance Services to determine who or what influenced OPM to include in its annual call letter a statement which would encourage carriers to capture discounts from non-PPO medical providers. We also reviewed the House and Senate Appropriation Committee Reports for the Treasury, Postal Service, and General Government Appropriation bills for 1993 through 1995.

Due to time constraints, we were not able to perform sufficient procedures to identify health care providers that entered into a non-directed PPO contract arrangement with a vendor based solely on the possibility of becoming a part of that vendor's directed PPO network or to remain competitive. While we did make some limited inquires, those inquires were insufficient to either confirm or deny whether these were substantive reasons for entering into a non-directed PPO arrangement.

[*31]

EXHIBIT 1

FLOW OF DISCOUNT ARRANGEMENTS



[*32]

EXHIBIT 2

PREFERRED PROVIDER ORGANIZATIONS

Employee Organization	Multi-plan, Inc.	National Preferred Provider Network	United Payors & United Providers and America's Health Plan
American Foreign Service Protective Association			✓
American Postal Workers Union Health Plan			✓
National Association of Letter Carriers Health Benefit Plan	✓	✓	✓
Rural Carrier Benefit Plan			✓
Special Agents Mutual Benefit Association			✓

Vendors:

Multiplan, Inc.
115 Fifth Avenue
New York, NY 10003
Phone: (212) 780-2000

National Preferred Providers Network, Inc.
407 East Main Street
Middleton, NY 10940
Phone: (914) 343-1600

United Payor and United Providers/America's Health Plan
2275 Research Boulevard, Sixth Floor
Rockville, MD 20850
Phone: (301) 548-1000

[*33]

EXHIBIT 3

PREFERRED PROVIDER ORGANIZATIONS REVIEW
PREMIUM PAYMENTS
FOR PERIOD ENDING JUNE 30, 1997
(UNAUDITED)

DIRECT PPOs

CARRIER	PREMIUM PAYMENTS	SAVINGS	RATIO
APWU	203,027,700	29,825,317	14.69%
GEHA	477,451,392	106,799,463	22.37%
MHBP	903,996,936	179,148,767	19.82%
NALC	323,256,494	58,873,579	18.21%
POST-MASTER	29,373,621	5,007,328	17.05%
SAMBA	41,255,807	10,839,047	26.27%
Gross	1,978,361,950	390,493,501	19.74%
Fees	29,854,245	29,854,245	
Net	1,978,361,950	*360,639,256	18.23%

NONDIRECT PPOs			
CARRIER	PREMIUM PAYMENTS	SAVINGS	RATIO
AFSPA	18,858,169	392,495	2.08%
APWU	203,027,700	2970380	1.46%
GEHA	477,451,392	7573843	1.59%
NALC	323,256,494	12,573,249	3.89%
RURAL	85,536,527	1,630,669	1.91%
SAMBA	41,255,807	311,073	0.75%
Gross	1,149,386,089	25,451,709	2.21%
Fees		4,345,450	
Net	1,149,386,089	21,106,259	1.84%

* Amounts saved may be further reduced as a result of financial incentives given to subscribers.

EXHIBIT 4

Vendors	Arrang-ement between Vendor/ Network	Arrang-ement between Net-work/ Provider	Total Number of Errors	Total Amount of Sample Errors
National Preferred Provider Network	3		3	$55.77
Multiplan	1		1	$1.87
United Payors & United Providers		4	4	$617.63
Total Errors	4	4	8	$675.27
Number of claim lines reviewed			600	$54,370
Error Rate			1.3%	1.24%

APPENDIX

SIGNIFICANT RESPONSES FROM AFFECTED PARTIES

1. William E. Flynn, III, Associate Director for Retirement and Insurance, Office of Personnel Management
2. Richard G. Miles, President, Government Employees Hospital Association, Inc.
3. Carroll Midgett, Chief Operating Manager, Health Plan Department, American Postal Workers Union, AFL-CIO
4. Calvin Engel, Assistant Administrator, National Association of Letter Carriers Health Benefit Plan
5. S. Joseph Bruno, Chief Financial Officer, United Payors & United Providers
6. Sidney L. Meyer, Executive Vice President, MultiPlan

United States
Office of
Personnel Management

Washington, D.C. 20415

MEMORANDUM FOR PATRICK E. MCFARLAND
INSPECTOR GENERAL

FROM: WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR
FOR RETIREMENT AND INSURANCE

Subject: Silent PPOs, Report Number 99-00-97-054

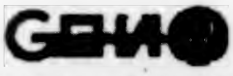
Thank you for sharing your "Report on the Use of Silent PPOs in the Federal Employees Health Benefits Program" with us. We were impressed with the rigor and thoroughness of the report and are gratified that it confirmed our belief that the carriers which contract with us engage in lawful and ethical practices in obtaining discounts from health care providers.

We were pleased that the small number, only 1.3 percent, of discounts that occurred in a manner inconsistent with agreed upon contract terms were inadvertent errors which were neither material nor indicative of any systemic problem in need of correction. While much concern has been expressed about "silent PPOs" which take inappropriate discounts from health care providers, your report definitively shows that if "silent PPOs" exist at all, they clearly do not exist in the Federal Employees Health Benefits Program. What do exist are legitimate non-directed PPOs which produce material savings for the carriers that employ them. While these savings do not approach those obtained by the same carriers from their directed PPO networks, they still consti-

tute savings which would not otherwise have been achieved.

We hope that your report will put to rest the need that some parties have expressed for action on our part to address a "silent PPO" problem that does not exist.

[*37]



The Health Plan for Federal Employees

February 16, 1998

Office of the Inspector General
Office of Personnel Management
Attention: Sanders Gerson
Room 6400
1900 E St. N.W..
Washington, D.C. 20415

Subject: Draft Copy of Report on Silent PPOs

Dear Mr. Gerson:

I have reviewed the report and was relieved to see that the conclusions supported our position on this matter. As a matter of editorial comment only I have a couple of observations from reading the report.

The report discusses the concept of an "ideal" PPO. I believe that the term "ideal" used in this context is too subjective and creates the impression that one type of network is better than another. In reality, what may be desired by a provider may not be ideal from a payor standpoint or from that of another provider.

Although many PPOs do provide services related to controlling utilization this is not universal and the

savings derived from utilization controls is minor in comparison to the savings from contractual agreements with providers. In my opinion, whether or not a PPO provides utilization controls is not relevant to the subject matter. I might also suggest that you substitute "traditional" for "ideal" to describe directed networks in the second paragraph on page 2.

I thought the report language could be strengthened to note that although a small number of errors were detected there did not appear to be a systematic practice of deception nor were any of the errors made or a material nature.

[*38] Overall, I was very pleased with conclusions reached and am hopeful that this report will put the issue to rest so we can all devote our efforts to more substantive topics. Thank you for giving me the opportunity to review the draft report and to provide comment.

Sincerely,

s/

Richard G. Miles
President

Health Plan Department
American Postal Workers Union, AFL-CIO
P.O. Box 420, Baltimore MD 21203

February 17, 1998

Mr. Sanders P. Gerson
Deputy Assistant Inspector General for Audits
Office of Personnel Management
1900 E. Street NW – Room 6400
Washington, D.C. 20415

Dear Mr. Gerson:

We appreciate the opportunity to comment on the Office of Inspector General's report on "Silent PPOs" before its release to the House Committee on Government Reform and Oversight.

Based on a review of the draft report dated February 6, 1998 and discussions with the OIG audit staff, it is our understanding that the four APWU claim lines in question (out of 120 claims reviewed) involved agreements between the hospitals and a network which required steerage of subscribers through financial incentives in order for the discounts to be given. While the contract between APWUHP and UP & UP did not require steerage and the contract between Up & Up and the network did not require steerage, the contract between the network and the providers apparently required steerage.

Currently, the APWUHP is working with UP & UP to determine what alternatives are available to eliminate the conflicting language in the provider – network contracts.

Additionally, the 4 claims lines out of 120 claims reviewed represents a 97% processing accuracy rate which is well above the 95% processing accuracy standard set by the Office of Personnel Management.

[*40] If you have any questions regarding the enclosed information, you can reach me at (301) 622-5554.

Cordially.

s/

Carroll Midget,
Chief Operating Manager

NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN

[illegible]

Delivered via Facsimile and
U.S Mail

February 17, 1998

[illegible]

Office of the Inspector General
U.S. Office of Personnel Management
Room 6400
1900 E Street, N.W.
Washington, DC 20415

Attention: Sanders Gerson, Deputy Assistant Inspector General for Audits

Dear Mr. Gerson:

Thank you for the opportunity to review the Office of the Inspector General's (OIG) preliminary report on silent and/or non-directed PPO type programs. As this report indicates, PPO arrangements are defined and applied by FEHBP carriers with differing methodologies. Because of this, it is difficult to draw a parallel between the FEHBP carrier's PPO type applications.

Reviewing this OIG draft suggests that OIG is only releasing aggregate fees (i.e. the amounts paid to PPO contractors for savings on discounted services) for the FEHBP program. The NALC Health Benefit Plan believes that OIG's final release should not disclose individual negotiated fees with any given vendor - being that they are competitively derived. Releasing these fees will violate the Plan's disclosure terms of PPO agreements and may jeopardize our capability to obtain future competitive bidding with PPO and discounted provider groups.

Again, thank you for giving the NALC Health Benefit Plan an opportunity to review and comment on this report before its final release.

Sincerely,

s/

Calvin Engel
Assistant Administrator

February 17, 1998

Sanders P. Gerson
Deputy Assistant Inspector General for Audits
U.S. Office of Personnel Management
Office of Inspector General
1900 E Street, N.W., Room 6400
Washington, DC 20415

Dear Mr. Gerson:

Thank you for the opportunity to meet with you and Mr. Gibbons on Friday afternoon regarding the results of the Office of the Inspector General's Review ("OIG Review") of the use of Preferred Provider Organizations ("PPOs") in the Federal Employees Health Benefit Program ("FEHBP"). We, the management team at United Payors & United Providers, Inc. ("UP&UP"), want to reiterate to the OIG that:

(1) The review was performed in a professional and efficient manner with knowledgeable staff.

(2) The OIG's extension of their FEHBP Review to include PPO provider contracts was an important element of examining the benefits derived by the FEHBP. The Review validated the importance of the PPO networks in obtaining savings for not only the FEHBP but also for the individual plan members.

(3) The OIG's Review was an important step in determining that there was "no evidence found to confirm the use of payment schemes that victimize health care providers in the

FEHBP". Further, we appreciated your comments at our meeting which indicated that a reader of your Review report should determine that (a) there was no evidence of "Silent PPO" activity, (b) the FEHBP derived significant benefits from PPOs, and (c) there is no need for further audit work by the OIG or any other oversight body regarding the use of PPOs.

We believe that if the FEHBP were to be subjected to a further review, it would be imperative for the OIG, or other agency of the Federal Government, to audit all vendors (so-called Directed and non-Directed PPOs) that provide financial intermediary services between FEHBP payors and health care providers. These intermediaries (PPOs) offer identical products that are utilized by the commercial payor community (i.e., major insurance companies). From our perspective, it is important to note that discounts enjoyed by the FEHBP through so-called Directed PPO products are also supported by a similar [*43] commercial contracts. In fact, if such Directed PPO arrangements were not supported by a valid contract, there would be evidence of a "Silent PPO" and an abusive provider relationship. Specifically, we believe that all other so-called Directed PPOs should be subjected to the same contractual scrutiny that other FEHBP financial intermediaries have experienced. To drive this point home, if there is a need to expand your Review, we believe it should be expanded to the other PPOs serving the FEHBP.

Audit/Review Conclusions Should Be Clearly Stated

We are pleased with the results of your Review and we recommend that your report consist of an opinion paragraph (presented on page 1 of your report) that

indicates the scope of your Review and the results obtained as noted in your headline comments A and B on page 6 of your draft report. The substantial background information section of your report inadvertently allows the reader to believe that unverified industry data and processes represent the results of your Review. Specifically, we believe that there is no support for the following health care terminology used in your Report:

- Financial incentives
- Ideal PPO
- Steerage
- Directed PPO
- Non-Directed PPO

If the reader of your Review report requires background information, we suggest an appropriate Appendix which describes how the $1 trillion health care industry operates including the Blue Cross and other so-called Directed PPOs. This write-up should also include common health care terminology and not "hearsay" comments which you describe as anecdotal information from the Committee staff and other special interest groups.

UP&UP is a public company required to make disclosures to the Securities and Exchange Commission, therefore, we are confident that our business would be characterized using the following informational points:

- ✓ UP&UP's clients include all major insurance carriers — Aetna, Cigna, John Hancock, United Healthcare, Prudential, Mutual of Omaha, etc. These clients use the same national health care network as the FEHBP.

- ✓ UP&UP is a financial services company that supports the health care industry. Insurance companies and other major payors design health plans for a full range of large and small group employers, unions and other Government employees that utilize the UP&UP network.
- ✓ UP&UP regularly communicates with its provider clients by describing how the beneficiaries of our payor clients use the provider network. [*44]
- ✓ UP&UP's contracts with its providers offer tangible benefits such as a prepayment of one month (1/12) of medical claims represented by all of UP&UP's payor clients. As of December 31, 1997, UP&UP has prepaid approximately $17 million in medical claims.
- ✓ UP&UP has contracted with hospitals, ancillary facilities and physicians that represent "high utilization" providers of the beneficiaries that are covered by the health plans of UP&UP's payor clients.
- ✓ UP&UP's national network product is based on certain principles:
  - UP&UP does not assume underwriting risk
  - UP&UP prepayments to providers do not require the provider to assume business risk (capitated payments do shift risk to the provider)
  - UP&UP facilitates the continued use of the health care provider by the beneficiary through positive communication (directories, 800 numbers, ID cards). "Steerage"

to hospitals is done by physicians and UP&UP believes that it is inappropriate to interfere with the doctor-patient relationship.

✓ The UP&UP network savings are <u>always</u> shared with the beneficiary. UP&UP believes that the waiver of a "co-payment" is a financial technique that is negative for the following reasons:

- Interference with the patient's relationship with their physician.
- Increase in health care costs, i.e.:

	UP&UP Relationship	Co-Payment Waiver Financial Technique
Hospital Bill	$1,000	$1,000
Contractual Allowance	(200)	(200)
Net Billing	800	800
Co-Payment Waiver (20%)	N/A	160
Total Health Care Cost to Payor (80/20 plans)	640	800
Increase Health Care Cost Shifting		20%

Further, as noted above, we believe that when a co-payment waiver is required to "so-called direct" a patient to a specific hospital, the FEHBP actually incurs a significant cost in addition to the PPO network access fee in order to achieve "steerage" (if one actually believes that anyone or anything steers a patient other than a physician).

[*45] Full Disclosure of Background Information is Needed to Make the OIG Report Complete

There are references to Chairman Mica, House Subcommittee on Civil Service, in your report. We believe that it would be important background information for Congressman Mica's comments on October 22, 1997 to be included in your report. An excerpt of his comments are:

> "The second major revision in the amendment deals with the most controversial matter in the bill: the question of 'silent PPOs'. Everyone acknowledges that Preferred Provider Organizations (PPOs) play an important role in today's health care market. Frequently, these PPOs negotiate discounted rate schedules with health care providers in exchange for certain incentives. The incentives may include an agreement to steer patients to the provider, in the case of so-called "directed PPOs', or they may include financial incentives such as prepayment or prompt payment in the case of so-called 'non-directed PPOs'. Both directed and non-directed PPOs provide legitimate and valuable benefits to health care providers, carriers, and patients.
>
> However, many believed that the original language placed non-directed PPOs at a

competitive disadvantage. That was not Chairman Burton's intent, and it is certainly not the intent of this subcommittee.

Silent PPOs', however, are another matter. These organizations take advantage of health care providers by arranging for a carrier to obtain access to discounted rates it is not entitled to. The first victims of this practice are the Doctors and Hospitals. But in the end, all of us will pay the price as the losses incurred by these providers are shifted to other consumers of medical services."

Also, an October 16, 1997 letter to John Mica from Constance A. Morella, M.C., Thomas M. Davis, M.C., Elijah E. Cummings, M.C. and Harold E. Ford, Jr., M.C. indicated that:

"We are writing to express our collective concerns about Section 5 of H.R. 1836. Currently, fee-for-service plans in the Federal Employees Health Benefits Program (FEHBP) are saving the government millions of dollars a year through their utilization of various savings initiatives, including non-directed efforts. Section 5 of H.R. 1836 would cost the FEHBP these savings and create an administrative burden that would increase administrative costs.

We are concerned about these increased costs to FEHBP, which would be borne jointly by the federal government and federal employees. Already, next year's premiums are rising, on average, by 8.5%. Increased costs caused by this legislation would almost certainly need to be addressed in both authoriz-

ing and appropriating legislation if Section 5 is enacted. The Office of Personnel Management (OPM) and carriers within the program have expressed concern over these additional costs. In the Congressional Budget Office's (CBO) first approximation, FEHB costs could increase by between $10 and $50 million a year after 1998 if Section 5 of H.R. 1836 were enacted. The governments share would be approximately 70 percent of that amount, split roughly equally between additional agency costs and government payments for annuitants.

Section 5 would legislate a mandate on the FEHBP, instead of leaving these issues to the marketplace to sort out. Our job is to protect the federal treasury and federal employees — not to become involved in private sector disputes."

[*46] Finally, you indicated during a telephone conversation with UP&UP that Congresswoman Morella had asked the OIG a series of questions concerning your Review and the scope of your work. We believe that the entire OIG response to Congresswoman Morella would represent important background data as an Appendix to your report.

Hearsay, Anecdotal Comments and Unsubstantiated Data Do Not Constitute a "Review Opinion"

We previously noted that your background data could easily be confused by a reader of your report to be the results of your Review. We reinforce our comments on the efficiency and effectiveness of your Review and we believe that your "Review Opinion" included in the second paragraph of page 7 of your

report should be on page 1, paragraph 1 of your report. Your opinion includes these important factual statements:

> "Our purpose was to determine whether the discount taken on each claim was pursuant to the medical providers membership in a non-directed PPO and was otherwise consistent with their contract. We found that in each instance, a series of contractual agreements was in place. These agreements were between the carrier and the vendor, the vendor and provider network or the provider, and the provider network and providers. Consequently, we found no evidence that the FEHBP carriers through its vendors used silent PPOs to access discounts."

The conclusion section of your report includes many industry statements that may not be universally accepted, terms without an appropriate definition and a conclusion sentence that is inconsistent with your Review opinion on page 7, paragraph 2. Specifically, your conclusion in the first paragraph on page 10 states:

> "Thus, these three factors combine to cause perhaps false expectations and confusion on the part of providers who may be expecting steerage but in fact entered into an agreement that does not require steerage."

The word "confusion" has a negative connotation. Of course a $1 trillion industry has "complex" elements. The providers in question are organizations with billions of dollars in revenue, sophisticated financial staffs and legal counsel representation. It is difficult

to believe that they do not understand contractual relationships entered into.

Specific Comments Concerning UP&UP's Review Items

With respect to the four UP&UP "errors" as presented in Exhibit 4, we believe that three of the four items noted are ad errors. Our support is as follows:

Monongalia General Hospital

This contract states on page 4, section 3.4, the following regarding incentives: [*47]

> "HPO will offer most favorable terms to payors that provide the greatest financial savings for Covered Subscribers to utilize the HPO network. All HPO Network payors provide financial incentives for covered subscribers that utilize the network. Financial incentives range from shared saving arrangements, to reduced or waived co-insurance/deductibles, to benefit differentials and planned design."

This section addresses two items:

(a) Most favorable terms to payors, and
(b) Financial incentives for covered subscribers.

Item (a) refers to offering the payor client a lower fee if they provide greatest incentives to their covered subscribers; while item (b) refers to financial incentives for covered beneficiaries. The contract specifically defines the range of financial incentives from "shared savings to benefit differentials". Our Payor clients utilize "shared savings" to meet the financial incentive contract requirement, **therefore, this does not constitute an "error"**.

Baptist Hospital of East Tennessee (page 4, section 3.4)
East Jefferson General Hospital (page 4, section 3.2)

These contracts state the following regarding incentives:

> "HPO will offer most favorable terms to Payors that provide the greatest financial savings for Covered Subscribers to utilize the HPO network."

The respective sections address "most favorable terms to Payors" and refers to offering the Payor client a lower fee if the Payor provides greatest incentives to their covered subscribers. There are no contractual requirements regarding financial incentives for covered subscribers, therefore this does not constitute an "error". Notwithstanding this, all our Payor clients utilize the "shared savings" financial incentive program for their covered subscribers. If the Payor client implements additional methods of financial incentives such as waived co-insurance and deductibles, benefit differentials, etc., then the fee paid by the payor client to access the network would be reduced.

Specific Comments Regarding Exhibit 3

As currently presented, Exhibit 3 does accomplish the objective stated at our meeting to "demonstrate that utilization of both Directed and non-Directed PPOs benefit the FEHBP program". However, the method in which the information is presented, and certain elements of the information, are unclear, inaccurate and misleading. The unclear, inaccurate and misleading elements are as follows:

(a) Net Direct PPO savings do not reflect the "actual" additional cost to the FEHBP of the

financial incentives (reduction or waiver of co-payments/ deductibles, etc.); and [*48]

(b) Non-Directed PPOs' savings ratio calculations are misleading. Specifically, the amount of premium payment is significantly overstated due to the fact that the premium payment must be reduced by the actual amount applicable to Directed PPOs to avoid double counting.

We have revised Exhibit 3 to reflect a clearer presentation of the data and it is included as an attachment to this letter for your consideration. We believe the revised Exhibit 3 reflects your stated objective "to demonstrate that utilization of both Directed and Non-Directed PPOs benefit the FEHBP program".

******

In closing, we apologize if the tone of our comments indicate any displeasure with the Review process by the OIG. In fact, we are pleased that the matter seems to be resolved since your Review indicated that there was no evidence of any "Silent PPO" activity. As a public company, we are sensitive about comments made concerning our business. We operate with strong business principles and our national health care network is used to process approximately $3 billion of medical claims for all major insurance carriers. As a public company, we know we are subject to public scrutiny and we are satisfied with the results of your Review. We do not believe, however, that government oversight should extend into a matter that is clearly governed by contractual relationships.

Thank you again for allowing us to comment on your draft Review report. Of course, we would be pleased

if our response (or portions of our response) is included as an Appendix to your final report as background information on the health care industry.

Very truly yours,

s/

S. Joseph Bruno
Chief Financial Officer

SJB/alw
Attachment

[*49] PRELIMINARY REPORT: FOR DISCUSSION PURPOSES ONLY
NOT FOR PUBLIC RELEASE

EXHIBIT 3
(revised)

PREFERRED PROVIDER ORGANIZATIONS REVIEW

PREMIUM PAYMENTS
FOR PERIOD ENDING JUNE 30, 1997

Carrier	Premium Payments	Net Savings	Ratio
APWU	$203,207,700		
GEHA	477,451,392		
MHBP	903,996,936		
POST-MASTER	29,373,621		

SAMBA	41,255,807		
AFSPA	18,858,169		
NALC	323,256,494		
RURAL	85,536,527		
Total	$2,082,936,646		
Net direct PPO savings (1)		$360,639,256	17%
Net non-direct PPO savings		21,106,259	1%
Total		$381,745,515	18%

(1) Directed PPO's by definition must utilize a direction mechanism in the form of financial incentives (reduction or waiver of co-payments and/or deductibles for the federal employee). These financial incentives are not included in this analysis as they were not available from the FEHBP Carriers. The impact of these financial incentives would be to reduce net savings since the FEHBP paid a larger portion of the premium payments (i.e., the reduction or waiver of the co-payments or deductible for the federal employee is borne by the FEHBP Carriers).

Sidney L. Meyer
Executive Vice President

February 19, 1998
Via Fax: 202-418-0630

United Stated Office of Personnel Management
Office of the Inspector General
1900 E Street, N.W., Room 6400
Washington, DC 20415
Attention: Sanders P. Gerson

Deputy Assistant Inspector General for Audits

Re: **Silent PPO Review**

Dear Mr. Gerson:

I am writing on behalf of MultiPlan, Inc., in response to the draft, preliminary Report (the "Draft Report") that you prepared on completion of your review of the use of "silent" and "non-directed" preferred provider organizations ("PPOs") within the Federal Employees Health Benefits Program ("FEHBP"). We appreciate the OIG's hard work on this complex and sensitive issue and the opportunity to comment on the Draft Report.

As an initial matter, we concur with your view that giving health payers access to provider discounts through subterfuge or misrepresentation would constitute, at the very least, an unethical practice in the FEHBP. MultiPlan, Inc. strongly opposes these so-called "silent" PPOs. We also are pleased, but not surprised, that OIG's review has confirmed that Mul-

tiPlan is not a silent PPO and does not engage in such practices. Indeed, OIG's review, which was performed in accordance with generally accepted government auditing standards for performance audits, demonstrates that MultiPlan had written contracts in place in every case reviewed and that all but one of the MultiPlan claims reviewed were processed in accordance with MultiPlan's provider contracts. In the case of that one claim, MultiPlan inadvertently extended a discount to the FEHBP plan of $1.87 -- a trivial error. As this example illustrates, MultiPlan's claim payment accuracy far exceeds the FEHBP's own standard for accuracy of payment. *See* Office of Personnel Management, *Financial Statements Fiscal Year 1996* at *56¬57*.

America's Managed Care Partner

115 Fifth Avenue
New York NY 10003-1004
Tel: (212) 780-2055
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[*51] We therefore ask that you expressly state in the final Report that MultiPlan is not a "silent" PPO and does not engage in "silent" PPO practices, and that all of MultiPlan's claims reviewed were processed under written contract administered in a manner that exceeds FEHBP standards for accuracy of payment

The OIG has conducted a careful and professional review of this matter The Draft Report, however, includes some language that is inconsistent with the OIG's data and conclusions as presented in the Draft Report. It also uses some terms in a manner that is misleading and inaccurate. We ask that you correct

these points, which are described below, in your final Report.

First, on pages 6-7, the Draft Report states that "anecdotal evidence" may justify concern on the part of the Committee on Government Reform and Oversight that medical providers arc perhaps being victimized. This "anecdotal evidence," however, is not disclosed. And, in any event, the OIG's factual investigation refutes this "evidence" and dispels any basis for concern. We urge that this passage be deleted, less it be quoted out of context in support of a conclusion directly contrary to that reached in the OIG's review. For the same reason, the discussion of claims payment should be deleted from section B, on pages 6-7. Rare instances of inaccurate payment under written contracts is a separate topic from "vitalization" of providers under "silent" PPOs, and is fully addressed in section C.

Second, the Draft Report inaccurately implies that surveyed vendor's contracts with network providers are "vague" and create expectations on the part of providers that are not being fulfilled. This unsupported conclusion is in stark contrast to the conclusion regarding contract compliance, which is supported by a detailed claims audit. The report does not cite a single instance in which the OIG concluded that a provider had reason to be confused regarding the terms of its contract with MultiPlan or one of the other vendors or in which a specific provider's reasonable contractual expectations were not met. For these reasons, the Draft Report's discussion regarding allegedly vague contract terms and unmet provider expectations should be deleted.

Third, the Draft Report's use of the terms "directed PPO" and "non-directed PPO" is inaccurate. Multi-

Plan is classified as "non-directed", but MultiPlan does provide varying degrees of direction in its work with FEHBA plans.

[*52] MultiPlan requires, for example, that its clients share with subscribers the savings realized from its provider discounts by calculating the subscriber's coinsurance payment on the basis of the discounted rate. This results in a direct reduction in out-of-pocket expenses or FEHBP subscribers who use MultiPlan network providers. If, as some suggest, financial incentives are essential to a directed PPO arrangement, then MultiPlan meets this definition.

But financial incentive are not the only effective way to steer subscribers to network providers. For example, MultiPlan maintains a web site referred service on the Internet that is so extensive and accessible that it won an award from USA Today. We encourage you to review the site, which is at http://ww.multiplan.com. Similarly, MultiPlan operates a 24-hour-a-day toll-free referral line staffed by nurses, and the FEHBA plans have been notified of this referral line. MultiPlan also offers a transfer assistance program that arranges for patients that are in a non-network hospital to be safely transferred to a network hospital.

Finally, steerage is not the only reason providers agree to extend discounts to MultiPlan, or example, MultiPlan's arrangements result in much better cash flow for network providers. MultiPlan requires its clients to make timely payment to providers and offer pre-audit payments and prepayment programs as a deposit or guarantee for bed days or for specific procedures. These programs provide concrete, financial benefits to MultiPlan's network providers. MultiPlan also provides quality support for network pro-

viders through its rural health care support, credentialing and certification, discount purchasing programs for medical services and supplies, and an extensive library of critical pathways that are shared with all of our network providers. These programs directly benefit our network providers. Equally important, however, they encourage high quality of care for FEHBP subscribers.

For these reasons, we urge you to revise the Draft Report to note that benefit differentials are not the only appropriate form of steerage, and that PPOs such as MultiPlan *do* direct subscribers to providers in their networks. In addition, we ask that the final Report state that steerage is not the only benefit that FEHBP providers can gain from membership in a PPO network.

Fourth, the Draft Report does not scrutinize the practices of entities that operate PPOs that the Draft Report labels "directed." Many of these entities, for example, contract with hospitals for an EPO rate, and/or HMO rates and/or for a PPO rate. The OIG review did not examine whether the directed PPOs accessed the correct rate in accordance with the contract term, to provide a more balanced assessment of whether health care providers are being "victimized" by FEHBP payers -- the stated purpose of the Draft Report -- the OIG's review should be expended to [*53] include the practices of so-called "directed" PPOs. If this is not practical at this time, the report should note a minimum that there is also the potential for abuse by the PPO's that the Draft Report labels "directed," and that the OIG has not reviewed their practices.

Fifth, the Draft Report should note that OPM's 1993 call letter encouraging FEHBP carries to obtain the

lowest price available for all goods and services is entirely consistent with existing legal requirements. *See* C.F.R. § § 1600 *et seq*. OPM obviously did not intend for the carriers to do this through unethical or illegal means.

In summary, Provider discount arrangement with PPO's exist today for a variety of reasons. These reasons include direction of patients, collection and cash flow advocacy and quality support. The depth of discount vary as does the reason for providing them. This is all part of the process that helps keep health care in America self regulated as to price and the world leader as to quality.

Again, we appreciate the opportunity to comment on the Draft Report.

Please call Harvey Sigelbaum or me if you have any questions, or if we can be helpful to you in any way.

Very truly yours,

s/

Sidney L. Meyer
Executive Vice President
Chief Legal and Legislative Affairs Officer

[*54]

VIII. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 5, UNITED STATES CODE

* * * * * * *

CHAPTER 59—ALLOWANCES

* * * * * * *

SUBCHAPTER IV—MISCELLANEOUS ALLOWANCES

* * * * * * *

§ 5948. Physicians comparability allowances

(a) Notwithstanding any other provision of law, and in order to recruit and retain highly qualified Government physicians, the head of an agency, subject to the provisions of this section, section 5307, and such regulations as the President or his designee may prescribe, may enter into a service agreement with a Government physician which provides for such physician to complete a specified period of service in such agency in return for an allowance for the duration of such agreement in an amount to be determined by the agency head and specified in the agreement, but not to exceed—

(1) * * *

(2) [$20,000] *$30,000* per annum if the Government physician has served as a Government physician for more than twenty-four months.

For the purpose of determining length of service as a Government physician, service as a physician under section 4104 or 4114 of title 38 or active service as a medical officer in the commissioned corps of the Public Health Service under Title II of the Public Health Service Act (42 U.S.C. ch. 6A) shall be deemed service as a Government physician.

* * * * * * *

CHAPTER 89—HEALTH INSURANCE

Sec.
8901. Definitions.

* * * * * * *

8903b. Authority to readmit an employee organization plan.

* * * * * * *

§ 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) * * *

* * * * * * *

[*55]

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agree-

ments, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee [organization;] *organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;*

* * * * * * *

§ 8902. Contracting authority

(a) * * *

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other

than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

[(2)] *(3)* The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

* * * * * * *

[(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.]

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

* * * * * * *

[*56]

§ 8902a. Debarment and other sanctions

(a)(1) For the purpose of this section—

(A) the term "provider of health care services or supplies" or "provider" means a physician, hospital, or other individual or entity which furnishes health care services or supplies;

(B) the term "individual covered under this chapter" or "covered individual" means an employee, annuitant, family member, or former

spouse covered by a health benefits plan described by section 8903 or 8903a; [and]

(C) an individual or entity shall be considered to have been "convicted" of a criminal offense if—

(i) * * *

* * * * * * *

(iv) in the case of an individual, the individual has entered a first offender or other program pursuant to which a judgment of conviction for such offense has been withheld;

without regard to the pendency or outcome of any appeal (other than a judgment of acquittal based on innocence) or request for relief on behalf of the individual or entity[.]; and

(D) the term "should know" means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;

(2)(A) Notwithstanding section 8902(j) or any other provision of this chapter, if, under [subsection (b) or (c)] *subsection (b), (c), or (d)*, a provider is barred from participating in the program under this chapter, no payment may be made by a carrier pursuant to any contract under this chapter (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment.

* * * * * * *

(b) [The Office of Personnel Management may bar] *The Office of Personnel Management shall* bar the following providers of health care services or supplies from participating in the program under this chapter:

(1) * * *

* * * * * * *

[(5) Any provider—

[(A)whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

[(B)that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.]

(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement [*57] *activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).*

(c) *The Office may bar the following providers of health care services from participating in the program under this chapter:*

(1) Any provider—

(A) *whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by*

a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially

in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.

[(c)] *(d)* Whenever the Office determines—

[(1) in connection with a claim presented under this chapter, that a provider of health care services or supplies—

[(A) has charged for health care services or supplies that the provider knows or should have known were not provided as claimed; or

[(B) has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which [*58] are of a quality that fails to meet professionally recognized standards for such services or supplies;]

(1) in connection with claims presented under this chapter, that a provider has charged for a health

care service or supply which the provider knows or should have known involves—

(A) an item or service not provided as claimed,

(B) charges in violation of applicable charge limitations under section 8904(b), or

(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);

* * * * * * *

[(d)] *(e)* The Office—

(1) * * *

* * * * * * *

[(e)] *(f)* In making a determination relating to the appropriateness of imposing or the period of any debarment under this section (*where such debarment is not mandatory*), or the appropriateness of imposing or the amount of any civil penalty or assessment under this section, the Office shall take into account—

(1) * * *

* * * * * * *

[(f)(1) The debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as may be specified in regulations prescribed by the Office.]

(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c)

shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).

* * * * * * *

(3) Any notice of debarment referred to in paragraph (1) shall specify the date as of which debarment becomes effective and the minimum period of time for which such debarment is to remain effective. *In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).*

(4)(A) A provider barred from participating in the program under this chapter may, after the expiration of the minimum period of debarment referred to in paragraph (3), apply to the Office, in such **[*59]** manner as the Office may by regulation prescribe, for termination of the debarment.

(B) The Office may—

(i) terminate the debarment of a provider, pursuant to an application filed by such provider after the end of the minimum debarment period,

if the Office determines, based on the conduct of the applicant, that—

(I) there is no basis under [*subsection (b) or (c)*] *subsection (b), (c), or (d)* for continuing the debarment; and

* * * * * * *

[(6) The Office shall, upon written request and payment of a reasonable charge to defray the cost of complying with such request, furnish a current list of any providers barred from participating in the program under this chapter, including the minimum period of time remaining under the terms of each provider's debarment.]

[(g)(1) The Office may not make a determination under subsection (b) or (c) adverse to a provider of health care services or supplies until such provider has been given written notice and an opportunity for a hearing on the record. A provider is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the provider in any such hearing.

[(2) Notwithstanding section 8912, any person adversely affected by a final decision under paragraph (1) may obtain review of such decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting that the decision be modified or set aside must be filed within 60 days after the date on which such person is notified of such decision.]

(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided

in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court **[*60]** *shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the*

record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.

(3) Matters that were raised or that could have been raised in a hearing under paragraph (1) or an appeal under paragraph (2) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

[(h)] *(i)* A civil action to recover civil monetary penalties or assessments under subsection [(c)] (d) shall be brought by the Attorney General in the name of the United States, and may be brought in the United States district court for the district where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered under this section shall be paid to the Office for deposit into the Employees Health Benefits Fund. *The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.*

[(i)] *(j)* The Office shall prescribe regulations under which, with respect to services or supplies furnished by a debarred provider to a covered individual during the period of such provider's debarment, payment or reimbursement under this chapter may be made, notwithstanding the fact of such debarment, if such individual did not know or could not reasonably be expected to have known of the debarment. In any such instance, the carrier involved shall take appropriate measures to ensure that the

individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment.

§ 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) SERVICE BENEFIT PLAN.—One Government-wide plan, *which may be underwritten by participating affiliates licensed in any number of States*, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title.

* * * * * * *

[*61] § 8903b. Authority to readmit an employee organization plan

(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

(b) A contract for a plan approved under this section shall require the carrier—

(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.

§ 8909. Employees Health Benefits Fund

(a) * * *

* * * * * * *

(e)*(1)* Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

REPORT OF THE COMPTROLLER GENERAL OF THE UNITED STATES

Conflicts Between State Health Insurance Requirements And Contracts Of The Federal Employees Health Benefits Carriers

U.S. Civil Service Commission

Many States have health insurance requirements that conflict with provisions of the contracts negotiated by the Civil Service Commission and the Federal Employees Health Benefits carriers. Some doubt and confusion exists on the part of the Federal health insurance carriers and the States regarding the applicability of State requirements to these contracts. GAO believes the Subcommittee on Retirement and Employee Benefits, Committee on Post Office and Civil Service, should consider legislation to clarify whether State requirements can alter the terms of contracts negotiated under the Federal Employees Health Benefits Act.

MWD-76-49 *Oct. 17, 1975*

B-164562

The Honorable Richard C. White
Chairman, Subcommittee on Retirement
and Employee Benefits
Committee on Post Office and Civil Service
House of Representatives

Dear Mr. Chairman:

Your February 20, 1975, letter asked for information on State health insurance requirements which conflict with contracts negotiated between the Federal Employees Health Benefits carriers and the Civil Service Commission. You asked that we identify those State health insurance requirements which conflict with contracts of these carriers, and if feasible, determine (1) what the increase in costs would be to the Federal Employees Health Benefits program if the contracts were changed to include all benefits required by the States and (2) what the savings would be if these State requirements were preempted by Federal statute.

The report discusses various State conflicts, the carriers' methods of dealing with these conflicts, and the position of the Civil Service Commission and certain carriers regarding the applicability of State requirements to the Commission's health insurance contracts. Because of an absence of cost data, we could not determine what the increased cost to the Federal Employees Health Benefits program would be if the contracts were changed to include all benefits required by the States, nor could we determine what the savings would be if the State requirements were preempted by Federal statute.

We found that (1) some doubt and confusion exists among the carriers and the States regarding the

applicability of State requirements to these contracts and (2) the States are becoming increasingly active in establishing and enforcing health insurance requirements. Accordingly, we believe that the Subcommittee should consider legislation to clarify whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act.

As your office requested, we did not obtain the Commission's or the carriers' formal comments on this report, but the contents of the report were discussed with Commission officials.

Sincerely yours,

s/

Comptroller General
of the United States

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ABBREVIATIONS

CSC Civil Service Commission

FEHB Federal Employees Health Benefits
GAO General Accounting Office
NALC National Association of Letter Carriers
GEHA Government Employees Hospital Association

[*i]

COMPTROLLER GENERAL'S REPORT

CONFLICTS BETWEEN STATE HEALTH INSURANCE REQUIREMENTS AND CONTRACTS OF THE FEDERAL EMPLOYEES HEALTH BENEFITS CARRIERS

U.S. Civil Service Commission

DIGEST

The Federal Employees Health Benefits program provides health insurance coverage to program participants through contracts negotiated between the Civil Service Commission and health plan carriers. These contracts specify the benefits to be provided by the plans and the premium cost which is shared by the Government and enrollees. (See p. 1.)

Some States have established health insurance requirements that conflict with the provisions of these contracts, such as requiring recognition of certain practitioners not covered by Federal Employees Health Benefit plans. These conflicting requirements have not, to date, greatly increased the costs of the Federal Employees Health Benefits program. (See p. 5.)

Many States have not attempted to enforce their requirements that conflict with these health

plans. In other States, the carriers have been successful in convincing the States that the Federal employees' plans are exempt from State requirements. Other States have enforced their requirements but have not done so uniformly for all carriers in the Federal program. (See p. 5.)

[*ii] For example, the Indemnity Benefit Plan pays for chiropractic services in Nevada, as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractic services only in New York and Montana where State laws require coverage for such services. The Service Benefit Plan has been required to pay for these services only in Maryland and Oklahoma. Even in the States that have enforced conflicting requirements, few Federal enrollees are aware of the States' requirements, and, as a result, most enrollees do not attempt to obtain reimbursement for chiropractic services. (See p. 9.)

The cost of revising the carriers' contracts with the Civil Service Commission to include all benefits required by States is difficult to estimate because of such unknown factors as the potential utilization of these benefits. However, the Indemnity Benefit Plan believes they would have to increase their premiums by as much as five percent. (See p. 13.)

Some plans have requested the assistance of the Commission in obtaining exemptions from the State requirements, but the Commission has consistently taken the position that the States have the authority to regulate the plans. (See p. 16.)

Because of the large number of State requirements that conflict with the plans, and indications that States are becoming more active in enforcing them, it appears that such requirements could increasingly affect the benefits and costs of the program. (See p. 16.)

[*iii] CONCLUSIONS

There is some doubt and confusion on the part of the carriers and the States regarding the applicability of various State health insurance requirements to the Federal Employees Health Benefits program contracts.

As a result, decisions regarding health benefits or services required by States, but not covered under the Federal Employees Health Benefits program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Because the States are becoming more active in establishing and enforcing health insurance requirements which conflict with the carriers' contracts with the Commission, these conflicting requirements can be expected to result in:

-- increased premium costs to both the Government and the program enrollees and

-- a lack of uniformity of benefits for all enrollees in the same plan, which results in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States. (See p. 16.)

RECOMMENDATION TO THE SUBCOMMITTEE

In view of (1) the doubt and confusion that exists among the health benefit carriers and some States and (2) the increased activity of the States in estab-

lishing and enforcing health insurance requirements, GAO recommends that the Subcommittee consider legislation to clarify its intent as to whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act. (See p. 17.)

[*1] CHAPTER 1

INTRODUCTION

We reviewed the problems resulting from conflicts between the benefits and services provided under the Federal Employees Health Benefits (FEHB) program and various State requirements in response to a February 20, 1975, request from the Chairman, Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service. (See app. I .)

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The Federal Employees Health Benefits program, established by the FEHB Act of 1959, provides health insurance coverage for about 3 million Government employees and annuitants and 6 million dependents. The cost of the program, which is shared by participating employees and the Government, was about $1.6 billion for fiscal year 1974, of which the Government's share was estimated at $960 million. The total cost of the program for fiscal year 1976 will be about $2 billion.

The program is administered by the Civil Service Commission (CSC) which contracts for coverage through the following four types of health plans:

-- Service Benefit Plan: A Government-wide plan under which the carrier, Blue

Cross/Blue Shield, generally provides benefits through direct payments to physicians and hospitals. About 5.6 million of the 9 million program participants are covered by this plan.

[*2] -- Indemnity Benefit Plan: A Government-wide plan under which the carrier, Aetna Life Insurance Company, provides benefits by either reimbursements to the employees or, at their request, direct payments to physicians and hospitals. About 1.3 million program participants are covered by this plan.

-- Employee Organization Plans: These plans, available only to individuals and members of their families who are members of the sponsoring organizations, provide benefits either by reimbursing employees or, at their request, by paying physicians and hospitals. Twelve such plans provide coverage to about 1.5 million program participants.

-- Comprehensive Medical Plans: These plans, available only in certain localities, provide (1) comprehensive medical services by teams of physicians and technicians practicing in common medical centers or (2) benefits in the form of direct payments to physicians with whom the plans have agreements. Thirty-two such plans provide benefits to about 600,000 program participants.

The premium costs to the Government and enrollees and the benefits provided by each of the FEHB

plans are specified in contracts negotiated each year by CSC and the carriers. Although the benefits and premium costs may differ among the various plans--and between various options available under the same plan--all those enrolled under a particular plan and option are entitled to receive the same benefits and pay the same premiums.

[*3] Even though the contracts between CSC and the various FEHB carriers require uniform coverage for all enrollees in each option of each plan, a few States have required certain FEHB carriers to provide benefits or services not covered in the contracts with CSC.

In addition, some FEHB carriers are being taxed by States while others are not, which affects the premium rates. For example, some States require certain FEHB carriers to pay premium taxes while other FEHB carriers are exempt and some States require reserves for contingencies and epidemics, in addition to the reserves required by CSC. We have previously reported on the tax and reserve issues (B-164562, Oct. 20, 1970, May 22, 1972, and Nov. 7, 1974). The premium taxes paid by the various FEHB carriers in calendar year 1974 are shown in appendix II.

SCOPE OF REVIEW

The objective of our review was to obtain information on the conflicts between State health insurance requirements and the FEHB program and the effect such conflicts have on the cost of the program.

The review included an examination of records and discussions with officials at CSC headquarters, Washington, D.C., and at the offices of the carriers for the Service Benefit Plan, the Indemnity Benefit

Plan, and several of the employee organization plans. We did not visit all of the States or review all State laws and regulations; rather, we obtained most of our information on actual and potential conflicts in [*4] benefits and services from the FEHB carriers. Also, because of the absence of cost data pertaining to benefits or services required by States but not included in FEHB carriers' contracts with CSC, we could not determine (1) the cost to the program if all such benefits were included in the FEHB plans' contracts or (2) the savings if such State insurance requirements were preempted by Federal law.

[*5] CHAPTER 2

CONFLICTS BETWEEN STATE HEALTH INSURANCE REQUIREMENTS AND FEHB CONTRACT PROVISIONS

A number of State health insurance laws, regulations, and Attorney Generals' opinions are beginning to have an impact on the coverage provided under the FEHB plans. It can reasonably be expected that if these State requirements were publicized and strictly enforced by the States, the costs of the FEHB program could be increased substantially.

The existing conflicts between the FEHB carriers' contracts with CSC and the State requirements have, to date, not had a great impact on the FEHB program costs, primarily because

- even when the States have ruled that conflicting State health benefit requirements are applicable (even if not provided in the FEHB contract), the FEHB enrollees do not usually know about the State laws and regulations and therefore do not pursue their claims with the carriers and

-- both the States and the carriers are unsure of the States' rights to impose State requirements on Federal contracts.

In connection with the latter point, many States that have insurance requirements that apparently conflict with benefits and services provided by FEHB plans have not attempted to enforce their requirements. In other States, the FEHB carriers have been successful in convincing the States that they are exempt from State requirements. [*6] Some States that have enforced their requirements, have not done so uniformly to all FEHB plans in those States. This could be, however, because enrollees in some plans are not aware of State requirements.

CSC's position on this matter has been that (1) the States have the authority to regulate and tax FEHB carriers, (2) it neither interprets nor enforces State laws, and (3) the FEHB carriers are free to take whatever steps are available to test the applicability of State laws.

There is some doubt and considerable confusion among the carriers and the States regarding the applicability of various State health insurance laws to the FEHB contracts.

As a result, decisions regarding the health benefits or services allowed under the FEHB program are, to a large extent, made on a State-by-State and a claim-by-claim basis. Descriptions of conflicts that the individual carriers have experienced with various State requirements follow.

INDEMNITY BENEFIT PLAN

Although Aetna has usually been successful in convincing State insurance commissions that the In-

demnity Benefit Plan is exempt from State laws and regulations, there have been exceptions.

Aetna has established standard responses to satisfy various States on the applicability of State insurance laws and regulations to the Indemnity Benefit Plan contracts. If a State asks why Aetna has denied [*7] a claim for a certain expense not covered by the plan, but required by the State, Aetna's first response has been that the plan is a group policy issued in the District of Columbia and is, therefore, not subject to the laws of that State. Until recent years, the States generally accepted this response.

According to Aetna officials, however, a few States have recently passed laws applicable to all group contracts regardless of where the policy was issued. In addition, Aetna stated that a few States have taken the position that, regardless of the wording of the State law, it applies to all contracts regardless of where they were issued. In these instances, Aetna tells the State that its plan is written pursuant to a special act of the Federal government and is not subject to State law or regulation. According to Aetna, this reply was accepted by all States until 1973.

In 1973, however, Nevada refused to recognize this argument and directed Aetna to pay for chiropractic services which were not included in its FEHB contract.

In June 1973, Nevada officials informed Aetna that in 1970 the State Legislature amended Nevada statutes to require coverage of chiropractic services and that Nevada's Attorney General had rendered an opinion in February 1973 which stated, in part, that:

"Nevada law currently requires coverage for chiropractic services in all individual, group or blanket health policies used in this State, regardless of the effective date or date of issuance to any such policy."

[*8] In September 1973, Nevada told Aetna that whenever the Indemnity Benefit Plan covers Nevada residents it is subject to State law. Nevada further stated that unless Federal legislation expressly preempted the Indemnity Benefit Plan from State law, Aetna's contention of Federal preemption would not be considered valid.

As a result, Aetna proposed to CSC that it either (1) join Aetna in court action to contest Nevada's requirements or (2) allow Aetna to include chiropractors in the plan's definition of doctors. Aetna estimated the additional premium necessary to cover this inclusion would range from 1 to 2 percent (about $2-4 million).

CSC declined to participate in a suit over this matter, but authorized Aetna to pay claims for services provided by chiropractors in Nevada. Aetna accepted CSC's decision, with the understanding that the cost of such claims be paid by CSC from its contingency reserve. This understanding was subsequently incorporated into the Indemnity Benefit Plan contract.

Aetna has successfully contested claims for chiropractic services in Missouri, Ohio, South Dakota, and Washington. In all cases, Aetna convinced the States that since the Indemnity Benefit Plan was under the FEHB program, it is exempt from State requirements. Beneficiaries in California and Florida have also had disputes with Aetna over claims for

chiropractic services. The insurance commissioners in these States, however, ruled that they lacked jurisdiction over FEHB plans.

[*9] In addition, Aetna has been involved in a dispute with Maryland concerning services provided by certain psychologists. Maryland law requires payment for services provided by licensed or certified psychologists, regardless of whether they are clinical psychologists. Aetna denied a claim in Maryland on the grounds that a licensed psychologist was not a clinical psychologist as defined in its contract. However, Aetna subsequently paid this claim as directed by the State.

According to Aetna officials, they have also disputed claims involving various State requirements in Montana, North Dakota, and Texas. Aetna did not give us details on these disputes but said no payments have been made for the disputed claims.

Aetna provided us examples of recent actions by States that may increasingly affect the FEHB plans (see app. III). In one example, the Nevada legislature enacted a law, effective July 1, 1975, requiring health insurance policies to include coverage for services by persons licensed in Nevada to practice traditional oriental medicine, including acupuncture. According to Aetna officials, payment may have to be made for these services, which are not included in its FEHB contract.

Aetna officials told us that annual premium fees for the Indemnity Benefit Plan would have to be increased by 5 percent or about $11 million, to cover all benefits required by States but not included in the FEHB contract. Aetna believes that FEHB plan carriers should be exempt from State requirements on

the grounds that the FEHB Act preempts State regulations.

[*10] SERVICE BENEFIT PLAN

The Service Benefit Plan, provided by the National Associations of Blue Cross and Blue Shield plans, has also experienced conflicts with States involving practitioners and benefits. We were told by an association official that State conflicts have been discussed with CSC, but the associations have not formally requested CSC to help them contest the right of States to enforce their requirements.

Although freestanding surgical facilities are not covered under the Service Benefit Plan, because these facilities do not meet the plan's criteria for hospitals, information provided by CSC indicates that the plan makes payments for services of such facilities in 21 States. An association representative said recognizing these facilities was a management decision, since recognition is required by law in some States. CSC has not objected to the plan's coverage of treatment in these facilities, because it is less expensive than providing similar services in regular hospitals and, therefore, does not adversely affect the cost to the FEHB program.

Chiropractic services are not a covered benefit under the Service Benefit Plan. However, according to the carrier for the plan, payment is made for these services in Maryland and Oklahoma at the insistence of these States. The Service Benefit Plan has not been required to make payment for chiropractic services by any other State, including Nevada, which has required payment for these services by Aetna's Indemnity Benefit Plan. This could be because en-

rollees of the Service Benefit Plan are unaware of the State's requirements.

[*11] Other State regulations which conflict with the Service Benefit Plan, but have not been contested as yet, involve treatment for nervous and mental conditions, alcoholism, and drug addiction. For example, North Dakota recently passed a law requiring health insurance coverage for persons suffering from mental illness, alcoholism, and drug addiction. This law requires that benefits be provided for treatment by partial hospitalization which is defined as "that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment." However, the Service Benefit Plan does not cover such partial hospitalization.

Similarly, the Massachusetts legislature has passed a law--to become effective on January 1, 1976--which provides guidelines on benefits for nervous and mental conditions and alcoholism. The law requires that a group medical service agreement in that State include provisions for payment of benefits for inpatient confinement in a mental hospital for at least 60 days of any calendar year. The Service Benefit Plan, however, has a lifetime maximum of $50,000 for benefits provided for nervous conditions and mental illness.

Also under Massachusetts law, coverage of at least $500 will be required for outpatient services at any licensed alcoholism treatment facility. The Service Benefit Plan recognizes only a facility meeting its definition of hospital.

[*12] EMPLOYEE ORGANIZATION PLANS

A National Association of Letter Carriers (NALC) official stated their plan is not paying for

any benefits or services not covered in their FEHB contract. Accordingly, NALC has refused to pay claims for chiropractic services in Oklahoma; the State has not contested NALC's action.

NALC was the only employee organization plan that provided us estimates of the cost to cover those benefits required by States but not covered in its FEHB contract. NALC estimated that its annual premium fees would have to be increased by $4 million to cover the services of chiropractors and by $3 million to cover the services of general psychologists.

This position contrasts to that of the Mutual of Omaha Insurance Company, which underwrites six FEHB employee organization plans. A Company official said New York and Montana require coverage of chiropractic services and the six FEHB plans which it underwrites are complying with these requirements.

The Government Employees Hospital Association (GEHA) cited several instances where it believed conflicts existed between State requirements and its FEHB contract. One of these involved the recognition of psychologists, which, at one time, were not covered under GEHA's FEHB contract.

A conflict occurred in Missouri where GEHA was directed to--and did--pay for psychiatric services rendered by an osteopath. GEHA denied the claim because osteopaths were not licensed to provide psychiatric services. [*13] The State's basis for directing payment was that GEHA's contract provided for services rendered by doctors of medicine and licensed doctors of osteopathy.

GEHA officials also stated that in some cases they were required by Illinois and Nevada to pay for

certain chiropractic services which were not provided for in their FEHB contract; however, in other similar cases in the same States, GEHA was not required to recognize or pay for these services.

GEHA currently has a lawsuit pending in California concerning the payment of chiropractic services. The suit was filed by a chiropractor who was refused payment for services required by State health insurance laws, but not covered under GEHA's FEHB contract.

CARRIERS' CONTACTS WITH CSC REGARDING CONFLICTS

Several of the FEHB carriers--principally Aetna and NALC--have sought CSC assistance in attempting to resolve the conflicts between State health insurance requirements and FEHB contract requirements.

As previously mentioned (see p. 6), Aetna's position is that FEHB carriers should be exempt from State requirements because the FEHB Act preempts State regulations. Aetna bases its position on the McCarran-Ferguson Act (15 U.S.C. 1012(b)), which states, in part, that:

> "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance * * *." (Emphasis added)

[*14] Aetna points out that the FEHB Act states that "each contract shall contain a detailed statement of benefits offered and shall include such maximum, limitations, exclusions, and other definitions of bene-

fits as the Commission considers necessary or desirable." Therefore, according to Aetna, the FEHB Act specifically relates to the "business of insurance" and clearly comes within the exception section of the McCarran-Ferguson Act and should not be subject to State regulations.

Aetna informed CSC of its opinion that the terms of the FEHB contract must take precedence over State regulations, to protect the FEHB program from conflicting regulations and to permit uniform coverage for all Federal employees enrolled in the Indemnity Benefit Plan.

NALC has attempted to obtain exemption from State insurance regulations since Wisconsin, in December 1968 (1) required NALC to pay approximately $207,000 in premium taxes, penalty assessments, and penalty interest because NALC had not obtained a State license and (2) had, according to Wisconsin, engaged in unauthorized transaction of insurance business.

In August 1970, NALC requested CSC to support NALC's position that the FEHB Act supersedes State licensing of health benefits plans such as NALC's, and that the taxes, penalties, and interest payments imposed by Wisconsin conflict with the FEHB Act.

NALC's legal opinion submitted to CSC stated that Wisconsin's application of State insurance licensing requirements to an employee organization plan established under the FEHB Act violates the Supremacy Clause (Clause 2 of Article VI) of the United States Constitution, since "it intrudes upon an area preempted by federal law, obstructs and [*15] impairs the operation of an Act of Congress and frustrates effectuation of its policy."

In December 1970 and January 1971, two other employee organization plans--the United Federation of Postal Clerks and Rural Carrier Benefit Plan--joined NALC in seeking an amendment to the FEHB Act so that FEHB contracts would supersede, or take precedence over, State laws which conflict with FEHB contracts.

CSC's POSITION

CSC's position has been that "the States have the authority to both regulate and tax health insurance carriers operating under the Federal Employees Health Benefits Program of chapter 89 of title 5 of the United States Code." In response to the FEHB carriers' requests, CSC told the carriers that

- the FEHB Act was not designed to regulate the insurance business or to override any State regulatory scheme,
- no legal basis exists for CSC to issue a regulation restricting the applicability of State laws to FEHB contracts,
- CSC neither interprets nor enforces State laws, and
- the carriers are free to pursue whatever steps are available to them to test the applicability of a State law in a given situation.

In this regard, CSC's General Counsel has not agreed with the carriers' contention that the FEHB Act is exempt from State regulation because of the McCarran-Ferguson Act. Moreover, he does not believe the "supremacy clause," also known as the preemption doctrine, could be used [*16] as a legal

basis for issuing a regulation restricting the applicability of State laws with regard to FEHB contracts.

In a June 1975 letter to Aetna, CSC's Deputy General Counsel said the legislative history of the FEHB Act is nearly devoid of references to the relationship between the FEHB Act and State laws regulating the business of insurance. He pointed out that the House Committee on Post Office and Civil Service stated in a 1970 report that:

> "it is recommended that the Civil Service Commission take appropriate action to inform carriers that the fact they are administering a Federal contract is no reason for circumventing compliance with applicable State laws."

The Deputy General Counsel concluded that this remark, along with others, indicates that State law should be controlling. Furthermore, he said there is no mention of the McCarran-Ferguson Act in the legislative history of the original FEHB laws or subsequent amendments to it. Therefore, he does not view the history of the FEHB Act as supporting Aetna's position that the act was intended to constitute a specific and explicit congressional enactment regulating the business of insurance.

On June 26, 1975, Aetna requested CSC's official position of the applicability of State requirements to FEHB carriers. As of October 9, 1975, CSC had not responded.

CONCLUSIONS

There is some doubt and confusion on the part of the FEHB carriers and the States regarding the applicability of various State health insurance requirements to the FEHB contracts. As a result, deci-

sions [*17] regarding health benefits or services required by States, but not covered under the Federal Employees Health Benefits program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Because the States are becoming more active in establishing and enforcing health insurance requirements which conflict with the carriers' contracts with CSC, these conflicting requirements can be expected to result in

- increased premium costs to both the Government and FEHB plan enrollees and
- a lack of uniformity of benefits for all enrollees in the same plan, which results in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

RECOMMENDATION TO THE SUBCOMMITTEE

In view of (1) the doubt and confusion that exists among the health benefit carriers and some States and (2) the increased activity of the States in establishing and enforcing health insurance requirements, we recommend that the Subcommittee consider legislation to clarify its intent as to whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act.

APPENDIX I

APPENDIX I

Ninety-Fourth Congress

U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS
OF THE
COMMITTEE ON POST OFFICE AND CIVIL SERVICE
B-345-B RAYBURN HOUSE OFFICE BUILDING
Washington, D.C. 20515

February 20,1975

B-164562

The Honorable Elmar B. Staats
Comptroller General of the United States
U.S. General Accounting Office
441 G Street, NW.
Washington, D.C. 20548

Dear Mr. Staats:

It has recently come to our attention that certain inequities exist in the Federal Employees Health Benefits (FEHB) program due to conflicts between the FEHB contracts and various State statutes. For instance, in Arizona, benefits for chiropractic services are paid under the service benefit plan because such benefits are required by State statute even though they are not paid for Federal employees in all States. In addition, certain States have statutes which require health benefit plans to maintain special contingency reserves in addition to the reserves held under the FEHB program.

I would like the General Accounting Office to identify those State health insurance requirements which are in conflict with contracts of the FEHB carriers. If feasible, I would also like to know (1) [*19] what the increase in costs would be to the FEHB program if the contracts with the FEHB carriers were changed to include all benefits required by such State statutes and (2) what the savings would be if such State statutes were preempted by Federal statute. I would also be interested in any legislative changes that you believe might improve this situation.

Sincerely yours,

s/

Richard C. White
Chairman

[*20]

APPENDIX II APPENDIX II

PREMIUM TAX EXPENSES
FOR CALENDAR YEAR 1974
BY FEHB CARRIER

Plan	Premium tax expense in 1974	Number of enrollees	Per enrollee (annual)
Service Benefit Plan	$1,063,982	1,844,309	$ 0.58
Indemnity Benefit Plan	5,367,212	475,118	11.30

American Federation of Government Employees	149,914	15,317	9.79
Government Employees Hospital Association	-0-	23,067	-0-
National Association of Letter Carriers	-0-	147,964	-0-
Postmasters Benefit Plan	118,561	8,574	13.83
Rural Letter Carriers	337,501	28,836	11.70
American Foreign Service	96,837	10,031	8.66
Government Employees Benefit Association	99,184	8,486	11.69
Canal Zone	200,151	17,865	11.20
Special Agents Mutual Benefit Association	173,135	17,842	9.70
Mail Handlers	256,062	23,596	10.85
National Alliance	40,209	3,866	10.40
American Postal Workers	-0-	158,194	-0-

APPENDIX III APPENDIX III

151 Farmington Avenue
Hartford, Connecticut 06115

Malcolm McIntyre
Manager
Government Relations Group
Division

September 23, 1975

Mr. Gerald Miller
Supervisory Auditor
Government Accounting Office
Audit Site, Room 2456
U.S. Civil Service Commission
1900 E Street, N.W.
Washington, D.C. 20415

Dear Mr. Miller:

In accordance with your most recent request, I have reviewed some state laws enacted recently and inasmuch as these new statutes could impact on the payment of benefits and the implementation of the Federal Personnel Manual 890.1 regulations, as they relate to health benefits, I will give you a short resume of each law and regulation.

Arkansas has a law which became effective June, 1975, which requires recognition of chiropractors' charges if such services would have been payable if rendered by a physician.

In Colorado, a law will become effective on January 1, 1976 which will require basic coverages to include benefits for at least 45 days of in-patient care

or 90 days partial hospitalization (3-12 hours in hospital or licensed psychiatric hospital) for mental illness treatment. Comprehensive medical policies must include out-patient services for treatment of mental and nervous conditions which may be limited to $1,000 in a 12-month period. Also, coinsurance may not exceed 50%.

Another law in Colorado which will also be effective January 1, 1976 requires insurers to offer for inclusion in group health policies coverage for treatment of alcoholism. Minimum benefits required to be offered include 45 days in-patient care in a licensed hospital or a facility licensed by the Department of Health, and out-patient benefits to the extent of $500 in a 12-month period.

Effective October 1, 1975, a law in Connecticut will require that an employee or dependent, if the employee becomes ineligible for continued participation in a plan for any reason including death, be allowed to continue insurance for up to 39 weeks or until covered by another group plan after insurance would otherwise cease, upon payment of premiums to the policyholder.

Another law, which became effective on May 28, 1975, in Connecticut, amends the Mental Illness Law to make it applicable to renewed [*22] contracts to increase the covered period of confinement for mental and nervous conditions from 30 to 60 days, and to increase the level of coverage for out-patient treatment from $500 to $1,000.

Effective October 1, 1975, another law will become applicable in Connecticut which mandates home health care benefits. The maximum offered cannot be less than 80 visits in a calendar year or in any

continuous period of 12 months. Of concern to us is the fact that such care could be rendered by a person who does not meet the requirements for coverage under the provisions of the Indemnity Benefit Plan or the Uniform Plan.

In Idaho, a new law became effective on July 1, 1975. One of the provisions of this law is that any medical policy which includes maternity benefits must, upon discontinuance, provide the maternity benefits that would have been payable to persons pregnant at the time of discontinuance had the policy remained in force for a period of 12 months following discontinuance.

Effective October 1, 1975, a law will go into effect in Illinois which will require group coverage to continue for a period not to exceed six months from an employee's "termination date" (date employee fired, laid off, etc.), provided the employee agrees to pay the premium at the previous rate. The employer must meet special notice requirements to permit the terminated employee the option to elect the continued coverage. This law will only be effective until July 1, 1977.

In Louisiana, effective November 1, 1975; a new law will require recognition of a chiropractor's charges if such services would have been payable if rendered by a physician.

The Maryland Insurance Department has a proposed regulation which would prohibit coordination of benefits between "no-fault" automobile insurance and medical insurance policies. This proposed regulation would also be extraterritorial in nature. Of course, this would impact directly on the "double coverage" provision contained in the Indemnity Benefit Plan.

A law becomes effective in Massachusetts on January 1, 1976 requiring that all group hospital and surgical expense policies covering Massachusetts residents, and to individual policies issued in Massachusetts, offer benefits for expenses arising for treatment of mental illness at least equal to requirements that in-patient benefits for treatment in a mental hospital will be provided for at least 60 days in a calendar year if the hospital is under the supervision of the Department of Mental Health, or licensed by that Department, and for confinement in a licensed general hospital, benefits are to be provided on the same basis as for any other illness. For out-patient benefits for treatment of mental and nervous disorders, they are to be covered to the extent of $500 over a 12-month period if services are provided by a comprehensive health service organization, by a licensed or accredited hospital, by a community mental health clinic or day-care center providing mental [*23] health services as approved by the Department of Mental Health, or by consultations, diagnostic or treatment sessions when administered by a licensed psychotherapist or psychologist.

In Minnesota, a law was effective July 1, 1975 which requires coverage for in-patient hospital and medical expenses on the same basis as other benefits for the treatment of emotionally handicapped children in a residential treatment facility licensed by the Commissioner of Public Welfare.

Also in Minnesota, a law became effective on August 1, 1975 which requires coverage of at least 90% of the first $600 in any 12-month period for consultation, diagnosis and treatment for mental and nervous disorders while the insured is not a bed patient in a hospital.

Another Minnesota law, which was effective May 15, 1975, requires that coverage under a group health insurance policy, upon termination of employment, must be continued until either the employee is reemployed and eligible for another group health care coverage or for six months.

In Nevada, a law became effective July 1, 1975 which requires benefits for home health care or health-supportive services. On this same date, another law became applicable in Nevada which requires recognition of the charges made by a licensed doctor of traditional Chinese Medicine (acupuncture).

Effective January 1, 1976, New Hampshire will have a new law which requires benefits for losses arising from mental or nervous conditions to be at least equivalent to 45 days of in-patient confinement, and 100% of the first five visits (80% thereafter) for out-patient coverage limited to $500 in a calendar year.

On June 5, 1975, a law became effective in New Jersey which requires recognition of a chiropractor's charges if such services would have been payable if rendered by a physician.

In Oklahoma, there is a new law requiring that group health policies issued or delivered on or after January 1, 1976 provide for continuation of coverage for 30 days after termination of such policy, and requires specified extended benefits to employees who have been covered under the policy for at least six months, for a continuous loss which commenced while the insurance was in force.

On July 31, 1975, a law became effective in Wisconsin which requires coverage for out-patient services at a hospital or out-patient treatment facility, including services of a physician in connection with alcohol-

ism or drug abuse to the extent of the first $500 in any calendar year. The law, however, makes a distinction in mandating the level of coverage for mental illness. Out-patient treatment for mental illness which is rendered at any place other than under a community mental health program established by Section 51.42 of the Wisconsin Statutes, need only be covered to the extent of $500 in a [*24] calendar year. However, out-patient mental illness treatment rendered under a community mental health program must be paid for the first $500 in any calendar year. The effect of this is that no deductible or coinsurance is permitted until the $500 limit is reached in connection with out-patient alcoholic treatment of mental illness, no matter where the treatment is rendered, and in connection with the treatment of mental illness, no deductible or coinsurance is permitted until the $500 limit is reached if the out-patient care is rendered under a community mental health program. However, if the out-patient mental health care is rendered somewhere other than under the community mental health program, a deductible and coinsurance is permitted.

Of course, I am sure you realize that there are many other statutes effective in various states which would impact on the benefit provisions of both the Indemnity Benefit Plan and the Uniform Plan, as well as the Federal Employees Health Benefits regulations. I have pointed out the foregoing laws and regulations just to give an indication of how the additional benefits, for which premiums have not been considered under these plans, would increase the claim benefits payable. One must also consider the implications on the increased administrative costs inherent to us in tracking and providing coverage under all of the various state laws under these plans, and the implied

necessity of having to, in the future, print brochures for each state showing the various coverages which would be in effect and the benefits which would be payable in each state.

As relates to the regulations and laws of the states concerning continuation of coverage, etc., it would be necessary for the Civil Service Commission to make a determination as to whether or not the states' laws or regulations would apply, or whether the Federal Employees Health Benefits regulations would apply under these circumstances.

All in all, I am sure that you realize our assumption that a 5% premium increase would be necessary for the Indemnity Benefit Plan for 1976 in order to pay benefits for services required by the various states is only for a one-year period, and that the cost would escalate in the future as more and more of the states' laws became applicable to these plans, or the states passed laws which would impact on the benefit structures of these plans.

I very much appreciate your request for this additional information, and please be assured that if I may be of further assistance to you, you need only call upon me.

Sincerely,

s/

Malcolm McIntyre, Manager
Group Government Relations

MM/cb

ECORD
AND
BRIEFS

DEC 19 2016

No. 16-149

IN THE
Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ Of Certiorari
To The Supreme Court Of Missouri

BRIEF FOR PETITIONER

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QUESTIONS PRESENTED

The Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, governs the health benefits of millions of federal workers and dependents, and authorizes the Office of Personnel Management ("OPM") to enter into contracts with private insurance carriers to administer benefit plans. FEHBA expressly "preempt[s] any State or local law" that would prevent enforcement of "[t]he terms of any contract" between OPM and a carrier which "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Id.* § 8902(m)(1). In a 2015 regulation, OPM codified its longstanding position that FEHBA-contract provisions requiring carriers to seek subrogation or reimbursement "relate to ... benefits" and "payments with respect to benefits," and therefore FEHBA preempts state laws that purport to prevent FEHBA insurance carriers from pursuing subrogation and reimbursement recoveries. 5 C.F.R. § 890.106(h). Expressly disagreeing with multiple federal circuits and state appellate courts, the Missouri Supreme Court nevertheless construed FEHBA not to preempt such state laws—explicitly refusing to accord any deference to OPM's regulation. A majority of the court further concluded that Section 8902(m)(1) violates the Supremacy Clause of the U.S. Constitution. The questions presented are:

1. Whether FEHBA preempts state laws that prevent carriers from seeking subrogation or reimbursement pursuant to their FEHBA contracts.

2. Whether FEHBA's express-preemption provision, 5 U.S.C. § 8902(m)(1), violates the Supremacy Clause.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

All parties to the proceeding are named in the caption.

Xerox Recovery Services, Inc. (formerly known as ACS Recovery Services, Inc.) intervened as an additional defendant in the case, but Xerox and Nevils subsequently settled the claims as between themselves. Xerox is no longer a party to this litigation.

Pursuant to this Court's Rule 29.6, petitioner Coventry Health Care of Missouri, Inc. (formerly Group Health Plan, Inc.) states that it is a wholly owned subsidiary of Aetna Health Holdings, LLC (successor by merger to Coventry Health Care, Inc.). Aetna Health Holdings, LLC, in turn, is a wholly owned subsidiary of Aetna Inc. Aetna Inc. is a publicly traded corporation that has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

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BRIEF FOR PETITIONER

Petitioner Coventry Health Care of Missouri, Inc. (formerly Group Health Plan, Inc.) respectfully submits that the judgment of the Supreme Court of Missouri should be reversed.

OPINIONS BELOW

The Missouri Supreme Court's opinion under review (Pet. App. 1a-14a) is reported at 492 S.W.3d 918. That court's prior opinion (Pet. App. 44a-72a) is reported at 418 S.W.3d 451. The Missouri Court of Appeals' opinion (Pet. App. 33a-43a) is not reported but is available at 2012 WL 6689542. The Missouri Circuit Court's decision (Pet. App. 28a-32a) is not reported. The U.S. District Court for the Eastern District of Missouri's ruling remanding to state court (*id.* at 15a-27a) is not reported but is available at 2011 WL 8144366.

JURISDICTION

The Missouri Supreme Court entered judgment on May 3, 2016, accompanied by opinions adjudicating the federal questions presented here. This Court has jurisdiction under 28 U.S.C. § 1257(a). *See Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 476-87 (1975).

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS INVOLVED

Section 8902(m)(1) of Title 5, United States Code, provides:

> **§ 8902. Contracting authority**
>
> * * *
>
> (m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.
>
> * * *

Section 8913(a) of Title 5, United States Code, provides:

> **§ 8913. Regulations**
>
> (a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.
>
> * * *

Other pertinent constitutional, statutory, and regulatory provisions are reproduced in the Appendix at 1a.

INTRODUCTION

The health-insurance benefits the federal government provides to federal employees are a fundamentally federal concern. Congress explicitly determined that the administration of those benefits for the workforce of the *Nation's* government requires uniform, *national* rules. In the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, Congress empowered the Office of Personnel Management ("OPM") to establish—in contracts with private insurance carriers—the terms and conditions on which those benefits are provided to millions of federal workers and their families. And to prevent a patchwork of state laws from interfering with OPM's centralized oversight of FEHBA plans and frustrating plans' efficient operation, Congress expressly preempted state laws that purport to trump "[t]he terms of any contract" under FEHBA "which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Id.* § 8902(m)(1).

FEHBA's expansive express-preemption provision unambiguously supersedes state laws that nullify FEHBA contracts' reimbursement and subrogation provisions—which require carriers to recoup benefits they have paid to participants who also recover for the same costs from other sources. That follows inexorably from Section 8902(m)(1)'s text. Subrogation and reimbursement "relate to" the "extent" and "provision" of "coverage" and "benefits," and at a minimum to "payments with respect to benefits." State laws restricting such recoveries fall squarely within Section 8902(m)(1) and are preempted.

Congress's purposes powerfully reinforce that plain-text interpretation. Congress enacted (and later broadened) Section 8902(m)(1) to prevent divergent state-law requirements from creating disuniformity, cost inefficiency, and unfairness to participants in the same plan living in different States. Preempting state laws that restrict subrogation and reimbursement recoveries directly "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts," and "translate[s] to premium cost savings for the federal government" (ultimately, taxpayers) and "FEHB enrollees." OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29,203, 29,203 (May 21, 2015) ("*Final Rule*") (Pet. App. 158a).

OPM has long maintained this sensible, straightforward reading of FEHBA, which uniformly prevailed for decades. Lower-court confusion in recent years, however, led OPM to put any uncertainty to rest. In 2015, exercising its express statutory rulemaking authority, 5 U.S.C. § 8913(a), OPM adopted a notice-and-comment regulation codifying its "longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978," as preempting state antisubrogation and antireimbursement laws. *Final Rule*, 80 Fed. Reg. at 29,204-05 (Pet. App. 162a, 165a); 5 C.F.R. § 890.106. That regulation and the deference due under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), eliminate any possible doubt that FEHBA preempts such laws.

The Missouri Supreme Court nevertheless twice held in this case—both before and after OPM's regulation—that FEHBA does *not* preempt state laws, including Missouri's common-law doctrine, restricting subrogation and reimbursement by FEHBA carriers. But none of the grounds it asserted for refusing to apply FEHBA's preemption clause to such laws can be reconciled with the statute or this Court's teaching. Although the court purported to interpret Section 8902(m)(1)'s text, it addressed only selected words—which it construed implausibly—and disregarded other parts of the text altogether. And it never confronted Congress's purposes at all.

The decision below compounded its error by refusing to accord *any* weight to OPM's interpretation. The court did not question the reasonableness of OPM's reading; it held that *Chevron* deference does not apply *at all* because OPM's regulation concerns preemption. The court believed that a presumption against preemption applies instead, and that it compels a miserly construction of FEHBA's preemptive reach. That holding has things exactly backwards. This Court's decisions firmly establish that *Chevron* applies with full force to an agency's interpretation of the scope of a statute that clearly preempts *some* state laws. And the anti-preemption presumption the Missouri Supreme Court substituted for *Chevron* has no application to *express*-preemption clauses—least of all one like Section 8902(m)(1) concerning the *federal* government's provision of benefits for *federal* workers under contracts with a *federal* agency.

The Missouri Supreme Court's artificially narrow construction of FEHBA—if left to stand—will undermine the efficient and fair administration of FEHBA plans. That holding may potentially subject

carriers to class-action liability, even punitive damages, merely for fulfilling their contractual duties to the federal government. Yet the errors and harmful consequences of the court's misreading of the statute pale in comparison to its further holding that FEHBA's preemption provision is *unconstitutional*, and thus presumably preempts nothing. A supermajority of the court concluded, in a concurrence that is also binding precedent in Missouri state courts, that Section 8902(m)(1) violates the Supremacy Clause by purportedly elevating contracts over state laws. That holding rests on a distortion of the statute. Properly construed, FEHBA fully comports with the Clause: It is Section 8902(m)(1) itself that preempts state laws, which is all the Constitution requires.

At a minimum, FEHBA can reasonably be interpreted in that way, and thus must be so construed to avoid any putative constitutional doubt. The Missouri Supreme Court contravened the constitutional-avoidance canon by *creating*, rather than avoiding, a massive constitutional infirmity that the statutory text does not compel. The court's misguided rationale, moreover, would cast grave doubt on other important statutes containing similar preemption provisions—from the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, to the Federal Arbitration Act, 9 U.S.C. § 2.

This Court should reverse the Missouri Supreme Court's erroneous judgment and reaffirm the fundamental principles of federal law that the state court jettisoned. The Court should hold that FEHBA—in light of its plain text, Congress's purposes, and OPM's longstanding, reasonable interpretation—validly supersedes state-law restrictions on subrogation and reimbursement terms of FEHBA contracts.

STATEMENT

1. Congress enacted FEHBA in 1959, creating the Federal Employees Health Benefits Program (the "Program") to provide health-insurance benefits for federal workers. Federal Employees Health Benefits Act of 1959, Pub. L. No. 86-382, 73 Stat. 708. Congress sought to "assure maximum health benefits for [federal] employees at the lowest possible cost to themselves and to the Government." H.R. Rep. No. 86-957, at 4 (1959) (J.A.272-73). It authorized a federal agency—the Civil Service Commission, later replaced by OPM—to administer the Program, including by "prescrib[ing] regulations necessary to carry out" the statute, 5 U.S.C. § 8913(a), and by entering into contracts with private insurance carriers that administer FEHBA plans, *id.* § 8902(a), in which the agency specifies the "limitations, exclusions, and other definitions of benefits as [it] considers necessary or desirable," *id.* § 8902(d).

Today, the FEHBA Program is "the largest employer-sponsored health benefits program in the United States." Press Release, OPM, *Open Season for Federal Health Benefits, Dental and Vision Insurance, and Flexible Spending Accounts* (Sept. 28, 2016), http://tinyurl.com/jcebm2n. The Program covers "[a]pproximately 85 percent of all Federal employees," *ibid.*—more than 8 million federal workers and dependents—and pays out tens of billions of dollars in benefits annually. *Final Rule,* 80 Fed. Reg. at 29,203 (Pet. App. 160a). The federal government (ultimately, the public) pays the lion's share of premiums (typically 72%)—more than $30 billion each year—and participants pay the remainder. *Ibid.*; 5 U.S.C. § 8906(b)(1). Premiums are deposited into a special U.S. Treasury fund (the "Fund"). *Id.*

§ 8909(a). "[C]ommunity-rated" carriers, which set premiums based on demographics or other attributes of a pool of participants, receive premiums from the Fund up front, from which they pay benefits. 48 C.F.R. §§ 1602.170-2, 1632.170. "Experience-rate[d]" plans, which set premiums based on "actual paid claims" and other costs, draw on the Fund to pay benefits case-by-case. *Id.* § 1602.170-7.

2. In the 1970s, Congress became concerned about state regulation of FEHBA plans, which had "[i]ncreased premium costs to both the Government and enrollees" and created "[a] lack of uniformity of benefits" even "for enrollees in the same plan." H.R. Rep. No. 94-1211, at 3 (1976) (J.A.338). "[E]nrollees in some States" had to pay "a premium based, in part, on the cost of benefits provided only to enrollees in other States." *Ibid.*

Congress sought the views of the Civil Service Commission, which "strongly urge[d]" Congress to adopt an express-preemption provision. H.R. Rep. No. 95-282, at 3 (1977) (J.A.355). As it explained, FEHBA already "preempt[ed] state laws in this area," despite the lack of an express-preemption provision. *Ibid.* (J.A.354). But without an express statutory directive, "enforcement of this preemption policy w[ould] almost inevitably lead to time consuming and costly litigation with the states until [the Commission's] position is finally upheld by the courts," which is neither "necessary" nor "desirable." *Ibid.*; *id.* at 7 (J.A.361-62); S. Rep. No. 95-903, at 3-4, 8 (1978) (J.A. 369, 377).

The Commission also was concerned that—although it understood FEHBA itself as preempting state laws, and FEHBA authorized the Commission to issue regulations to "carry out" the statute,

5 U.S.C. § 8913(a) (1970)—the statute did not afford the agency sufficiently "clear authority to issue regulations" addressing the scope of preemption specifically. S. Rep. No. 95-903, at 4 (J.A.370). The Commission's legal counsel expressed similar views in correspondence with carriers—summarized in a 1975 Comptroller General report to Congress that likewise recommended legislation clarifying the limits of state law. *See* Comptroller General of the United States, Gen. Accounting Office, Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers 15-17 (1975) (J.A.565-67).

Congress adopted the Commission's suggestion, seeking to "clear up the doubt and confusion" and "to clarify the Federal Government's and the Civil Service Commission's authority to regulate implementation of the law." S. Rep. No. 95-903, at 4 (J.A.369-70). In 1978, Congress amended FEHBA by adding an express-preemption provision, *see* Act of Sept. 17, 1978, Pub. L. No. 95-368, 92 Stat. 606, which provided:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1) (1982).

After decades of additional experience, Congress concluded that this express-preemption provision did

not go far enough. Congress accordingly amended Section 8902(m)(1) in 1998 to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997) (J.A.403). The 1998 amendments broadened Section 8902(m)(1) in two respects. First, they expanded the range of FEHBA contract terms that state laws may not supersede, to include not just terms that "relate to the *nature* or *extent* of coverage or benefits" or benefit payments, but also terms that relate to the "*provision*" of those things. Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (emphases added). Second, Congress deleted the proviso limiting preemption to state laws "inconsistent" with FEHBA contracts. *Ibid.*; *see also* H.R. Rep. No. 105-374, at 16 (J.A.416-17); S. Rep. No. 105-257, at 9, 14-15 (1998) (J.A.456, 468). As amended, Section 8902(m)(1) now provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

3. The same year Congress enacted FEHBA's original preemption provision, it created OPM, which replaced the now-defunct Commission in administering FEHBA. Civil Service Reform Act of 1978, Pub. L. No. 95-454, §§ 201, 906(a)(2), 92 Stat. 1111, 1118-19, 1224. OPM has overseen the Program ever since.

OPM has long included in its FEHBA contracts provisions requiring carriers to seek subrogation and reimbursement. *E.g.*, Standard Contract for Community-Rated Health Maintenance Organization Carriers § 2.5 (2000) ("2000 Standard Contract"), http://tinyurl.com/joeb6dc. Such provisions apply where a beneficiary receives benefits under her FEHBA plan, but also recovers—or has a right to recover—for the same costs from a third party. If the beneficiary has already recovered from the third party, the carrier must seek reimbursement from the beneficiary. If the beneficiary has not yet recovered, the carrier must seek recovery from the third party directly. OPM, *Proposed Rule*, *Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 931, 932 (Jan. 7, 2015) (Pet. App. 150a).

As OPM has explained, these reimbursement and subrogation recoveries by carriers tend to reduce the premiums that the government and participants pay for the benefits that participants receive. *See Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 151a). That is true for both types of FEHBA carriers—experience-rated and community-rated: Recoveries by both types "lower subscription charges," merely by "different mechanism[s]." Pet. App. 170a-71a. Experience-rated carriers remit recoveries to the Fund; the recoveries are used to "increase [plan] benefits," reduce future premiums, or refund past premiums. 5 U.S.C. § 8909(a)-(b). Community-rated carriers may keep recovered funds, but must take prior recoveries into account when calculating future premiums. *See* OPM, *Community Rating Guidelines* 6, 11 (2015), http://tinyurl.com/zfwvhdt. Because "[t]he premiums that community-rated carriers charge generally depend on the expected cost of providing

benefits," these "recoveries by community-rated carriers tend to reduce those expected costs, and thus the premiums." Pet. App. 171a.

OPM has understood Section 8902(m)(1) "since Congress enacted it in 1978" to preempt state laws restricting subrogation or reimbursement recoveries. *Final Rule*, 80 Fed. Reg. at 29,204 (Pet. App. 162a); *accord* OPM, FEHB Program Carrier Letter No. 2012-18, at 1-2 (June 18, 2012) ("2012 Carrier Letter") (Pet. App. 117a-18a). OPM's contracts have long provided that carriers' subrogation and reimbursement obligations apply *regardless* of whether state law otherwise bars subrogation or reimbursement, so long as the carrier subrogates for one or more private employee-benefit plans governed by ERISA. *See, e.g.*, 2000 Standard Contract § 2.5. This ensures that FEHBA plans receive equal treatment with private-sector plans governed by ERISA—which this Court has held preempts state laws that preclude insurance administrators from seeking reimbursement, *see FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-60 (1990).

4. OPM contracted with Coventry's predecessor to provide FEHBA benefits to federal employees in Missouri as a community-rated carrier. Pet. App. 45a. Coventry's contract provided that "[t]he applicable provisions of ... chapter 89 of title 5, United States Code [*i.e.*, FEHBA]" and "OPM's regulations as contained in part 890, title 5, Code of Federal Regulations, ... constitute a part of this contract," and that the contract's other provisions "shall be construed so as to comply" with those statutes and regulations. J.A.89. Any disputes over whether Coventry complied with its contract are governed by "United States law." J.A.234.

Coventry's contract further "direct[ed] [Coventry] to seek reimbursement or subrogation when an insured obtains a settlement or judgment against a tortfeasor for payment of medical expenses." Pet. App. 45a; J.A.120-21. Missouri common law "generally prohibits subrogation in personal injury cases by barring insurers from obtaining reimbursement from the proceeds an insured obtains following a judgment against a tortfeasor." Pet. App. 46a. Coventry's contract nevertheless required it to seek subrogation or reimbursement "in the same manner in which it subrogates claims for non-FEHB members," even in Missouri, because Coventry "subrogate[d] for at least one plan covered under" ERISA in Missouri. J.A.120-21; *see* J.A.77.

5. Respondent Jodie Nevils was a federal employee and participant in the Coventry plan in Missouri. Pet. App. 45a. He was injured in a car accident in 2006, and Coventry paid for his medical care. *Ibid.* Nevils also pursued a tort action against the driver responsible for his injury, and obtained a settlement. *Ibid.* Because Coventry's contract required it to seek reimbursement, it asserted (through a subcontractor) a lien on Nevils's settlement proceeds for $6,592.24, the amount Coventry had paid. *Ibid.* Nevils repaid that sum, satisfying the lien. *Ibid.*

Nevils then filed this class action against Coventry in Missouri state court, alleging that Missouri's common-law antisubrogation doctrine forbade Coventry from seeking reimbursement, and seeking (*inter alia*) actual and punitive damages. Pet. App. 45a; J.A.255, 259-63. Coventry removed the case to federal court, but it was remanded. Pet. App. 15a-27a.

Coventry sought summary judgment, arguing that FEHBA preempts Nevils's claims. Pet. App.

46a. The state circuit court granted summary judgment for Coventry, holding that FEHBA preempts Nevils's claims. *Id.* at 31a-32a. Nevils appealed, and the state court of appeals affirmed. *Id.* at 36a-43a.

6. The Missouri Supreme Court granted discretionary review. The United States filed an *amicus* brief supporting Coventry, arguing that FEHBA "[u]nambiguously [p]reempts" Missouri's antisubrogation doctrine. Pet. App. 175a; *id.* at 168a-85a. In 2014, the Missouri Supreme Court reversed in a divided decision ("*Nevils I*"). *Id.* at 46a-54a.

a. The majority held that Section 8902(m)(1) does not encompass state antisubrogation and antireimbursement laws. Pet. App. 46a-54a. It reasoned that *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006)—which addressed federal-court jurisdiction over reimbursement suits by FEHBA carriers—and a "presumption against preemption" require a narrow reading of Section 8902(m)(1). Pet. App. 48a-51a & n.1. The statute's "operative terms," the court held, "are 'relate to,' 'coverage' and 'benefits.'" *Id.* at 51a. It construed "relate to" as requiring a "direct and immediate relationship." *Id.* at 52a. It defined "coverage" as the "scope of the risks insured," without regard to subrogation or reimbursement recoveries, and "benefits" as *initial* payments participants receive before such recoveries. *Ibid.* Applying these definitions, the court held that FEHBA does "not preempt Missouri law barring subrogation" because subrogation "bears no immediate relationship to the nature, provision or extent of Nevils' insurance coverage and benefits" and affects only participants' "net financial position after the provision of insurance benefits." *Id.* at 53a.

b. Judge Wilson, joined by now-Chief Justice Breckenridge, concurred in the judgment. Pet. App. 55a-72a (Wilson, J., concurring in result). They "disagree[d]" with the majority's statutory interpretation, concluding that Section 8902(m)(1) plainly evinces Congress's intent to preempt antisubrogation and antireimbursement laws. *Id.* at 55a-56a, 59a-66a. "[B]enefit repayment terms," they explained, "are *related* to benefits because" an insured "does not care what his 'benefits' are if he will not be allowed to keep them"; and "terms requiring Nevils to *pay* benefits back to [Coventry] that [Coventry] previously had *paid* out ... relate to 'payment with respect to Nevils' benefits.'" *Id.* at 61a (brackets omitted).

Nevertheless, the concurring judges concluded that Section 8902(m)(1) does not preempt Missouri's antisubrogation law because (they opined) it is unconstitutional. Pet. App. 66a-71a. The statute, they asserted, violates the Supremacy Clause by "giv[ing] preemptive effect to the benefit repayment terms in [Coventry's] contract," not federal law. *Id.* at 67a.

7. Coventry sought certiorari, and this Court invited the United States' views. 135 S. Ct. 323 (2014). While Coventry's certiorari petition was pending, in January 2015, OPM commenced a notice-and-comment rulemaking to address the preemption issue. *Proposed Rule*, 80 Fed. Reg. at 931 (Pet. App. 148a). OPM proposed a regulation "reaffirm[ing]" OPM's longstanding position that subrogation and reimbursement provisions in FEHBA contracts "relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits)," and that FEHBA thus preempts state laws restricting such rights. *Id.* at 931-33 (Pet. App. 149a-53a). This interpretation, OPM explained, "comports

with longstanding Federal policy, lowers the cost of benefits, and creates greater uniformity in benefits and benefits administration." *Id.* at 932 (Pet. App. 149a). Subrogation and reimbursement recoveries also "lower subscription charges for individuals enrolled in" FEHBA plans. *Ibid.* (Pet. App. 150a). And OPM's reading "is consistent with the definition of subrogation and reimbursement ... and their relationship to benefits and the payment of benefits," and it "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." *Ibid.* (Pet. App. 151a).

After receiving public comments, OPM published its final rule in May 2015. *Final Rule*, 80 Fed. Reg. at 29,203 (Pet. App. 160a). The regulation mandates that "[a]ll health benefit plan contracts shall provide that the [FEHBA] carrier is entitled to pursue subrogation and reimbursement recoveries," and confirms that a carrier's "right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments." 5 C.F.R. § 890.106(a), (b)(1). Regarding preemption, the regulation states:

> A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 C.F.R. § 890.106(h). This regulation "formalizes OPM's longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978." *Final Rule*, 80 Fed. Reg. at 29,204 (Pet. App. 162a). That interpretation "applies to all FEHBA contracts," including "existing contracts." *Ibid.*

The United States thereafter filed its invited brief in this Court, explaining that *Nevils I* was "wrong" and "should be reversed." U.S. *Amicus* Br. 11-12, *Coventry Health Care of Mo., Inc.* v. *Nevils*, No. 13-1305 (U.S. May 22, 2015), 2015 WL 2457642. OPM's regulation, it argued, "adopt[ed] by far the best reading of the FEHB Act," "and, at a minimum, reasonably interpret[ed] a statute Congress charged OPM with administering," and is thus "entitled to the full measure of deference under *Chevron*." *Id.* at 12-13. The government recommended vacating and remanding for the state court to address that issue in the first instance. *Id.* at 11-12, 22. Adopting that suggestion, this Court granted certiorari, vacated, and remanded "for further consideration in light of [the] new regulations promulgated by [OPM]." 135 S. Ct. 2886 (2015).

8. On remand, Coventry urged the Missouri Supreme Court to revisit its reading of FEHBA, and at a minimum defer to OPM's regulation—and once again, the United States supported Coventry's position. Pet. App. 189a-203a. In a 2016 decision ("*Nevils II*"), the state court refused. *Id.* at 4a-13a.

a. The principal opinion, joined by five judges, declined to reconsider *Nevils I*'s analysis of the statute, and addressed only whether OPM's regulation changed the result. The majority acknowledged that OPM's construction of Section 8902(m)(1) was at least "plausible," and had "no doubt that there is

strong federal interest in regulating the provision of health insurance benefits for federal employees." Pet. App. 7a. The court nevertheless refused to accord any weight to OPM's interpretation. It asserted that this Court "has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause," and "[a]bsent binding precedent requiring such deference," the Missouri Supreme Court would not apply *Chevron*. *Id.* at 5a, 8a-12a.

Instead, the court again applied a presumption against preemption to construe Section 8902(m)(1) not to preempt state antisubrogation and antireimbursement laws. Pet. App. 6a-8a, 13a. "The fact that the FEHBA preemption clause is susceptible to alternate interpretations," it held, "counsels that preemption is warranted only if Congress expressed its clear and manifest intent that the purposes of FEHBA require the preemption of state antisubrogation laws." *Id.* at 7a.

b. Judge Wilson again concurred only in the judgment—joined again by Chief Justice Breckenridge, and this time by four other members of the court (who also joined the principal opinion). Pet. App. 14a (Wilson, J., joined by Breckenridge, C.J., and Fischer, Stith, Draper, and Russell, JJ., concurring in result); *id.* at 13a. Those six judges opined that, "for all the reasons stated in" Judge Wilson's "separate opinion" in *Nevils I*, Section 8902(m)(1) "is not a valid application of the Supremacy Clause," and therefore "does not displace Missouri law," because it purportedly "give[s] preemptive effect to the provisions of a contract between the federal government and a private party." *Id.* at 14a.

SUMMARY OF ARGUMENT

I. Section 8902(m)(1)—both by its terms, and as reasonably construed by OPM—preempts state laws that bar FEHBA carriers from seeking subrogation or reimbursement.

A. Section 8902(m)(1)'s text and purpose demonstrate unequivocally that Congress intended to preempt state laws restricting antisubrogation and antireimbursement recoveries by FEHBA carriers.

1. Section 8902(m)(1) expressly "supersede[s] and preempt[s]" state laws that impair "[t]he terms of any [FEHBA] contract ... which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). Laws restricting subrogation and reimbursement fall comfortably within that text. Subrogation and reimbursement provisions relate to the extent and provision of coverage and benefits because they make coverage and benefits *conditional* upon the carrier's right to recover the value of benefits it pays if a third party becomes obligated to pay the same costs. This Court's cases construing similar preemption clauses confirm this reading of FEHBA's plain text; indeed, the Court reached the same conclusion in the analogous context of private benefit plans governed by ERISA. *See FMC*, 498 U.S. at 58-60. At a minimum, subrogation and reimbursement relate to "payments with respect to benefits."

2. Congress's purposes in adopting (and expanding) Section 8902(m)(1) confirm this plain-text interpretation. As the United States explained in its prior briefing, antisubrogation and antireimbursement laws are "indistinguishable from the state mandated-benefit laws that Congress expressly targeted" in en-

acting that provision. Pet. App. 179a. Preempting state laws that restrict subrogation and reimbursement recoveries directly advances Congress's aim of facilitating uniform, fair administration of FEHBA plans nationwide. And it furthers Congress's goal of fostering cost efficiency, by preventing States from impeding carriers' cost-saving efforts.

3. Neither the presumption against preemption nor *McVeigh*, 547 U.S. 677, on which the Missouri Supreme Court relied, justifies its contrary interpretation. No such presumption applies to Section 8902(m)(1)—both because it is an *express*-preemption provision, and because it operates in a field implicating overriding federal interests in which the federal government has long regulated. Even where it properly applies, that presumption is merely a tie-breaking tool for resolving ambiguities, not a license to disregard clear statutory text and purpose.

Nor did *McVeigh*, as the court below believed, establish that Section 8902(m)(1) is ambiguous or must be construed narrowly. *McVeigh*'s holding concerned only federal-court *jurisdiction*. The Court expressly reserved judgment on the proper interpretation of Section 8902(m)(1), merely noting competing constructions that had been advanced principally by *amici* in that case, without choosing between them because they did not matter.

B. Even if FEHBA's text and purpose did not unambiguously resolve the question in Coventry's favor, OPM's reasonable statutory interpretation compels rejection of the judgment below. OPM's position, articulated in a notice-and-comment regulation promulgated pursuant to express statutory authority, is entitled to dispositive deference under *Chevron*. The decision below and Nevils conceded

that OPM's reading plausibly construes FEHBA's text, and neither disputed that it faithfully implements Congress's purposes.

The decision below instead refused to defer to OPM's position because it deemed *Chevron* categorically inapplicable to preemption clauses. This Court's precedent refutes that view. *Chevron* applies to *all* aspects of a statute an agency is charged with administering, *see City of Arlington* v. *FCC*, 133 S. Ct. 1863, 1874 (2013)—including the scope of a statute that preempts state law, *see, e.g.*, *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735, 743-44 (1996). The Missouri Supreme Court's view that the presumption against preemption trumps *Chevron* is backwards and irreconcilable with this Court's teaching.

II. Section 8902(m)(1) comports with the Supremacy Clause. The provision itself declares the state laws it covers "supersede[d] and preempt[ed]," simply defining the *scope* of preemption partly by reference to OPM's contracts. 5 U.S.C. § 8902(m)(1). It is thus the *statute* that displaces state law, to make room for FEHBA contracts to operate; that is all the Supremacy Clause requires. Federal statutes often preempt state laws by reference to particular types of contracts—from ERISA to the Federal Arbitration Act. The decision below would mean all of those statutes are constitutionally infirm also.

Even if Section 8902(m)(1) raised a serious constitutional question, it certainly *can* reasonably be read to mean that federal law has preemptive force. It therefore *must* be so construed to avoid, rather than create, a constitutional problem. The fair and efficient administration of the FEHBA Program depends on it.

ARGUMENT

I. FEHBA Preempts State Laws That Bar Carriers From Seeking Subrogation Or Reimbursement Recoveries.

Whether interpreted as an original matter, or construed in light of principles of administrative deference, FEHBA preempts state laws that restrict subrogation or reimbursement recoveries by FEHBA carriers. The Missouri Supreme Court's contrary conclusion contravenes the statute and this Court's precedent.

A. FEHBA Unambiguously Preempts State Laws Barring Subrogation Or Reimbursement By FEHBA Carriers.

The scope of preemption is, "at bottom," a question "of statutory intent." *Morales* v. *Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992). As with any statute, courts must discern Congress's intent by "'reading the whole statutory text, considering the purpose and context of the statute, and consulting any precedents or authorities that inform the analysis.'" *Kasten* v. *Saint-Gobain Performance Plastics Corp.*, 563 U.S. 1, 7 (2011) (citation omitted). All of those indicia demonstrate that Congress intended to preempt state laws that prevent FEHBA carriers from seeking subrogation or reimbursement. The deck-stacking presumption against preemption the decision below invoked is inapplicable, and in any event cannot overcome the overwhelming textual and contextual evidence of Congress's intent.

1. FEHBA's Text Unambiguously Preempts State Antisubrogation And Antireimbursement Laws.

Construing FEHBA's "pre-emption provision begins 'with the language of the statute itself,'" "'which necessarily contains the best evidence of Congress's pre-emptive intent.'" *Puerto Rico* v. *Franklin Cal. Tax-Free Tr.*, 136 S. Ct. 1938, 1946 (2016) (citations omitted). Because "'the statute's language'" here "'is plain,'" that "'is also where the inquiry should end.'" *Ibid.* (citation omitted).

Section 8902(m)(1) expressly "supersede[s] and preempt[s] any State or local law" that "relates to health insurance or plans" and that frustrates "[t]he terms of any [FEHBA] contract ... which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). State laws barring FEHBA carriers from seeking subrogation or reimbursement as required by their contracts fall squarely within that broad preemptive mandate. Antisubrogation and antireimbursement laws undisputedly "relat[e] to health insurance or plans." The only question is whether subrogation and reimbursement provisions "relate to" either "the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Ibid.* They do.

As this Court has "repeatedly recognized," the phrase "relates to" in preemption clauses "express[es] a broad pre-emptive purpose" with an "'expansive sweep.'" *Morales*, 504 U.S. at 383-84 (citation omitted); *accord Northwest, Inc.* v. *Ginsberg*, 134 S. Ct. 1422, 1428 (2014). Congress often employs that phrase (and indistinguishable variants) to reach everything that "'has a connection with, or reference

to,'" the topics the statute enumerates. *Morales*, 504 U.S. at 384 (citation omitted). Subrogation and reimbursement "relate to" the "extent" and "provision" of both "coverage" and "benefits" themselves, and to "payments with respect to benefits," in that sense.

a. Subrogation and reimbursement clauses relate to the "extent" and "provision" of employees' "coverage" and "benefits."

i. The ordinary meanings of those terms are undisputed. As the Missouri Supreme Court acknowledged, "coverage" in this context means "'the risks within the scope of an insurance policy,'" Pet. App. 52a (quoting *Black's Law Dictionary* 394 (8th ed. 2004) ("*Black's*"))—*i.e.*, in what circumstances, and under what conditions, the insurer has agreed to pay. *See also Webster's New International Dictionary* 613 (2d ed. 1949) ("*Webster's 2d*") ("The aggregate of risks covered by the terms of a contract of insurance."); *Webster's Third New International Dictionary* 525 (2002) ("*Webster's 3d*") ("protection by insurance policy"; "inclusion within the scope of a protective or beneficial plan"). And "benefits" in this setting refers to "'[f]inancial assistance that is received from ... insurance ... in time of sickness, disability, or unemployment.'" Pet. App. 52a (quoting *Black's* p. 167; omissions in original); *see also Webster's 2d* p. 253 ("Pecuniary help in time of sickness, old age, loss of employment, or the like"); *Webster's 3d* p. 204 (similar). The "extent" of coverage and benefits is simply the "amount ... extended," *i.e.*, their "size." *Webster's 2d* p. 900-01; *accord Webster's 3d* p. 805. And the "provision" of coverage and benefits means the "act or process of providing" them. *Webster's 3d* p. 1827; *accord Webster's 2d* p. 1995.

Subrogation and reimbursement clauses relate to both the extent (amount) and provision (process of providing) coverage and benefits because, by definition, such clauses make carriers' payments to participants "*conditional* upon a right to subrogation or reimbursement of equivalent amounts." *Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 150a) (emphasis added). If the FEHBA-plan participant has already recovered from a third party for the same costs, a reimbursement provision "require[s] the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided," 5 C.F.R. § 890.101(a), *i.e.*, to *pay back* some or all of the amount the carrier originally paid. If the participant has not yet recovered from a third party, a subrogation provision requires her to surrender her right to recover to the carrier—which becomes the "successor to the rights of" the participant. *Ibid.*

Subrogation and reimbursement rights relate to "coverage" because, by making carriers' payments *conditional* on recoveries (or rights to recover) from third parties, they limit the scope of risks an insurer takes on, and the circumstances in which the participant is entitled to have the carrier pay his medical costs. A carrier *without* subrogation and reimbursement rights undertakes a duty to bear those costs if any of the events listed in the policy occurs. A carrier *with* subrogation and reimbursement rights, in contrast, agrees to bear financial responsibility *only* if and to the extent those costs cannot be recouped from another source, such as a third-party tortfeasor.

For the same reason, subrogation and reimbursement rights relate to "benefits." The "financial assistance" a participant ultimately "receive[s]" from the carrier (*Black's* p. 167)—*i.e.*, the *net* amount she may retain under the terms and conditions of the contract—turns on whether and to what extent the carrier may seek reimbursement or subrogation. A reimbursement provision means the "enrollee's ultimate entitlement to benefit payments is *conditioned*" from the outset "upon providing reimbursement from any later recovery." *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1106 (10th Cir. 2015) (emphasis added). Similarly, when a carrier pursues subrogation, the "financial assistance" the participant received is effectively reduced by the value of the claim against the third party she surrenders to the carrier. "[R]eimbursement and subrogation provisions" thus "relate to ... 'benefits'" because they "are limitations on the payment of benefits." *Bell* v. *Blue Cross & Blue Shield of Okla.*, 823 F.3d 1198, 1203 (8th Cir. 2016) (omission in original).

Coventry's contract here, for example, "direct[ed] [Coventry] to seek reimbursement ... when an insured obtains a settlement or judgment against a tortfeasor for payment of medical expenses." Pet. App. 45a; J.A.120-21. Because Nevils obtained a settlement with a third party for his injuries, he was obligated to reimburse Coventry to the extent he recovered from the tortfeasor on account of his injuries. The amount of "benefits" Nevils is entitled to *keep* is the sum Coventry originally paid *minus* the sum Nevils had to *repay*. The gravamen of Nevils's claim is that Coventry in effect wrongfully retained benefits to which Nevils claims he is entitled. *See* J.A.260-61; *cf. Buckner* v. *Heckler*, 804 F.2d 258, 259-60 (4th Cir. 1986) (per curiam) (Medicare partici-

pant's "claim that she is entitled to [an] overpayment" claimed by Medicare intermediary under reimbursement provision "is, in essence, one for [M]edicare benefits").

At a minimum, subrogation and reimbursement rights "'ha[ve] a connection with, or reference to'" (*Northwest*, 134 S. Ct. at 1428 (citation omitted)) the "extent" and "provision" of coverage and benefits, which is all FEHBA requires. Such rights are *triggered* only if the carrier previously advanced payment on account of medical treatment—*i.e.*, provided benefits—for which the plan provided coverage, and for which a third party (such as a tortfeasor) is also responsible. And the sum a carrier may recoup depends on the *amount* of that payment. Subrogation and reimbursement clauses thus fall squarely within Section 8902(m)(1)'s plain terms.

ii. This Court has already concluded that reimbursement rights "relat[e] to" employee "benefits" in the closely analogous context of *private* employee-benefit plans governed by ERISA. *See FMC*, 498 U.S. at 58-60. ERISA's parallel preemption clause "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). *FMC* held that this preemption clause encompasses "antisubrogation law[s]" that "prohibi[t] plans from ... requiring reimbursement." 498 U.S. at 58, 60. Such laws "'relat[e] to' an employee benefit plan" because reimbursement affects how carriers "calculate benefit levels." *Ibid.* Laws barring reimbursement "requir[e] plan providers to calculate benefit levels in" States that have such laws "based on expected liability conditions that differ from those in States" that do not, changing the net amount carriers are obligat-

ed to pay. *Id.* at 60. That disparity "frustrate[s] plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *Ibid.*

FMC's reasoning is fully applicable to FEHBA. As multiple courts have recognized, given the parallels between the texts and contexts of ERISA's and FEHBA's "nearly identical" preemption clauses, *Pharm. Care Mgmt. Ass'n* v. *Rowe*, 429 F.3d 294, 299 n.2 (1st Cir. 2005) (per curiam), "precedent interpreting the ERISA provision" is "authority for cases involving the FEHBA provision," *Botsford* v. *Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002); *see also, e.g.*, *Aybar* v. *N.J. Transit Bus Operations, Inc.*, 701 A.2d 932, 935-36 (N.J. App. Div. 1997). If anything, *FMC*'s reasoning applies with even greater force to FEHBA—which concerns benefits not of *private* workers, but *federal* employees. There is certainly no reason to construe FEHBA's preemption provision more *narrowly* than ERISA's parallel provision. As the United States has explained, "[i]t is exceedingly unlikely that Congress intended a *broader* role for state law," or "desired *less* uniformity," "in the case of federal employees than in the case of private employees." Pet. App. 178a (emphases added).

iii. The Missouri Supreme Court acknowledged that subrogation and reimbursement rights are "triggered by the payment of benefits" and "affec[t] the parties' net financial position." Pet. App. 53a. It nevertheless concluded that subrogation and reimbursement do not "relate to" the "extent" or "provision" of "coverage" or "benefits." *Id.* at 1a-2a, 52a-54a. Its reasoning contradicts FEHBA and this Court's case law.

The court below asserted that "relate to" requires a "direct and immediate relationship" to coverage and benefits. Pet. App. 52a. It did not attempt, however, to square that construction with this Court's decisions expansively construing "relate to" in preemption clauses generally. And it never confronted *FMC*'s application of ERISA's parallel provision to reimbursement rights specifically.

The Missouri Supreme Court's application of its narrow reading of "relate to," moreover, is unsupportable. The court posited that reimbursement and subrogation rights lack a "direct and immediate relationship" to coverage or benefits because such rights do not change the amount that carriers pay *initially* on account of participants' injuries. Pet. App. 52a-53a; *see id.* at 1a-2a. That facile distinction between what an employee originally receives and what he ultimately keeps is illusory and defies economic logic. Nothing in the definitions of "coverage" and "benefits" (including those the court cited) supports focusing exclusively on the amount participants receive initially without regard to repayments that reduce that sum. And what matters to all concerned—participants, carriers, and OPM—is the *net* amount the carrier must pay, *i.e.*, the value the participant can ***keep***, which represents the true economic risk assumed by the carrier.

This Court has rejected similar ersatz distinctions in other preemption contexts. In *Northwest*, it held that a state-law claim concerning frequent-flyer miles used to reduce the prices consumers pay for flights and upgrades "'relate[d] to'" an airline's "'rates, routes, or services,'" and thus was preempted by the Airline Deregulation Act, 49 U.S.C. § 41713. 134 S. Ct. at 1430-31 (citation omitted). "[T]he fre-

quent flyer program," *Northwest* held, was "connected to the airline's 'rates'" because it affected the *net* prices program participants paid for airline services: "When miles are used" to obtain "tickets and upgrades," "the rate that a customer pays, *i.e.*, the price of a particular ticket, is either eliminated or reduced." *Id.* at 1428, 1431 (citation omitted). "The program" was "also connected to 'services,' *i.e.*, access to flights and to higher service categories." *Id.* at 1431. The plaintiff urged that his claim concerned only his frequent-flyer-program status *itself*, not access to or prices of flights and upgrades. *Ibid.* But that "proffered distinction," this Court held, "has no substance": The obvious goal of the plaintiff's claim was "to obtain reduced rates and enhanced services." *Ibid.*

Even apart from sweeping "related to" preemptive language, this Court has rejected similar distinctions advanced to evade preemption. In *Hillman* v. *Maretta*, 133 S. Ct. 1943 (2013), the Court addressed a federal statute regarding the analogous context of federal employees' life-insurance benefits. The Court held that the statute's provision prescribing who receives life-insurance payments impliedly preempted a state law directing recipients of life-insurance payments to transfer them to someone else. *Hillman* expressly rejected a purported distinction between the *initial* payment of benefits and a later *transfer* of benefit payments. *See id.* at 1952. It "makes no difference," the Court held, whether state law withholds benefits in the first instance or instead takes them away after they have been paid: "In either case, state law displaces the beneficiary selected" under federal law. *Ibid.*

b. Even if subrogation and reimbursement did not relate to coverage and benefits, state laws restricting subrogation and reimbursement still are preempted by another phrase in Section 8902(m)(1). FEHBA also explicitly protects from state-law interference terms related to the extent or provision of "*payments with respect to* benefits." 5 U.S.C. § 8902(m)(1) (emphasis added). That text unquestionably covers subrogation and reimbursement rights.

Subrogation and reimbursement recoveries themselves *are* "payments with respect to benefits": When a carrier exercises either right, it receives a "payment"—from the participant or a third party—"with respect to benefits" previously paid. At a minimum, as the United States has explained, subrogation and reimbursement "rights *relate to* benefit payments because they require a beneficiary to return benefits to the extent the beneficiary has been separately reimbursed for those benefits from a tort recovery." Pet. App. 176a (emphasis added); *accord Bell*, 823 F.3d at 1204. The whole point of subrogation and reimbursement is to facilitate *repayments* of benefits. Their practical effect is to *undo or reduce* a prior benefit payment. If these rights do not relate to payments with respect to benefits, nothing does.

Both Coventry and the United States brought FEHBA's "payments with respect to benefits" phrase to the Missouri Supreme Court's attention. Coventry Mo. S. Ct. Br. 38-40 (Nov. 16, 2015); Pet. App. 176a-77a. The court, however, never confronted this independently dispositive text. And its interpretation—focused exclusively on what a participant initially receives without regard to later repayments—reads "payments with respect to benefits" out of the stat-

ute. That reading contravenes courts' duty to "'have regard to *all* the words used by Congress,'" *United States* v. *Atl. Research Corp.*, 551 U.S. 128, 137 (2007) (emphasis added) (citation omitted), and to "'give effect, if possible, to every clause and word,'" *Duncan* v. *Walker*, 533 U.S. 167, 174 (2001) (citation omitted).

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Because the "'language'" of FEHBA's preemption clause "'is plain,'" the analysis ends where it begins: with the "'plain wording of the clause.'" *Franklin*, 136 S. Ct. at 1946 (citation omitted). By FEHBA's plain terms, state laws restricting subrogation and reimbursement are preempted.

2. Congress's Purposes Confirm That FEHBA Preempts Antisubrogation And Antireimbursement Laws.

Additional evidence of Congress's "purpose"—the "'ultimate touchstone' of pre-emption analysis," *Wis. Dep't of Indus., Labor & Human Relations* v. *Gould Inc.*, 475 U.S. 282, 290 (1986) (citation omitted)—cements this natural reading of FEHBA's text. "Statutory construction ... is a holistic endeavor," and even "[a] provision that may seem ambiguous in isolation" may be "clarified by the remainder of the statutory scheme," including where "only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law." *United Sav. Ass'n of Tex.* v. *Timbers of Inwood Forest Assocs.*, 484 U.S. 365, 371 (1988). Congress's manifest purposes in enacting FEHBA's preemption provision erase any possible doubt about its application here.

Congress originally enacted Section 8902(m)(1) to combat state-law interference with FEHBA plans. H.R. Rep. No. 95-282, at 2-5 (J.A.353-57); S. Rep. No. 95-903, at 2-5 (J.A.366-71); H.R. Rep. No. 94-1211, at 2-4 (J.A.337-40). Congress feared that divergent state-law requirements—including laws mandating particular benefits—would result in "[i]ncreased premium costs to both the Government and enrollees, and [a] lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States." H.R. Rep. No. 95-282, at 4 (J.A.355); *see also* S. Rep. No. 95-903, at 2 (J.A.366). After years of additional experience, Congress *broadened* Section 8902(m)(1) "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (J.A.403); *see also* S. Rep. No. 105-257, at 9, 14-15 (J.A.456, 468).

Construing Section 8902(m)(1) to preempt laws barring FEHBA carriers from seeking subrogation and reimbursement directly "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." *Final Rule*, 80 Fed. Reg. at 29,203 (Pet. App. 159a-60a). Subrogation and reimbursement recoveries yield substantial cost savings—"approximately $126 million" in 2014 alone—which "translate to premium cost savings for the federal government" (thus taxpayers) "and FEHB enrollees." *Ibid.*; *see also Helfrich*, 804 F.3d at 1106-07. That interpretation also directly advances the "strong federal interest in national uniformity in coverage and benefits," which

"include[s] uniform administration of the FEHB program across state lines." *Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 152a). Achieving that interest necessitates "uniform rules that affect the rights and obligations of enrollees in a given plan without regard to where they live." *Ibid.* As the United States has explained, "Missouri's anti-subrogation rule is indistinguishable from the state mandated-benefit laws that Congress expressly targeted with the enactment of the FEHBA preemption provision," as it "requires FEHB providers to provide Missouri consumers with FEHB benefits that consumers in other states do not receive under the terms of the same FEHB contract." Pet. App. 179a.

Reading FEHBA *not* to preempt state antisubrogation and antireimbursement laws, in contrast, would thwart Congress's aims. That view would invite a motley patchwork of State-specific restrictions that "is administratively burdensome, gives rise to uncertainty and litigation, and results in treating enrollees differently, although enrolled in the same plan and paying the same premium." *Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 152a). Such inconsistency would not only hamstring the cost-cutting efforts that Congress specifically intended to encourage, but also would be unfair to FEHBA enrollees. If state laws forbidding subrogation or reimbursement recoveries "surviv[e] preemption," the United States has explained, "the loser[s] will be FEHB enrollees in states that permit" those recoveries, "who will be subsidizing the more generous benefits that" such laws "effectively mandat[e] that FEHB carriers provide." Pet. App. 179a. This "cross-subsidization" unfairly advantages some participants at the expense of others, merely because of where they live, "creat[ing]

precisely the disuniformity that Congress intended to preclude." *Ibid.*

Indeed, as the government explained below, the clash between Congress's objectives and state laws restricting FEHBA carriers' ability to seek subrogation and reimbursement as their contracts require is so stark that such laws would be preempted even if FEHBA did not *expressly* displace them. Pet. App. 180a (citing *Arizona* v. *United States*, 132 S. Ct. 2492, 2505 (2012)). Independent of express preemption, state laws that pose "'an obstacle to the accomplishment and execution of the full purposes and objectives of Congress'" are impliedly preempted. *Hillman*, 133 S. Ct. at 1950 (citation omitted). Regardless of whether a statute contains an express-preemption clause, state laws that "'frustrat[e] the deliberate purpose of Congress'" may be preempted on that separate basis. *Id.* at 1949-55 (citation omitted) (holding state law impliedly preempted without addressing express preemption); *see also Geier* v. *Am. Honda Motor Co.*, 529 U.S. 861, 869 (2000). *A fortiori*, in construing the express-preemption provision that Congress *did* enact, Congress's purposes preclude according that provision an artificially narrow meaning that is at war with Congress's aims.

Congress's objectives in adopting and expanding FEHBA's express-preemption provision thus forcefully corroborate the best reading of its language. Even if Section 8902(m)(1)'s text in a vacuum could *also* plausibly bear the Missouri Supreme Court's crabbed construction, Congress's purposes in enacting it foreclose that reading. Yet the court below never confronted those purposes—in either of its decisions—let alone explained how its narrow reading could be squared with Congress's objectives.

3. Neither The Presumption Against Preemption Nor *McVeigh* Supports A Contrary Reading Of FEHBA.

The Missouri Supreme Court tellingly did *not* contend that FEHBA's plain language or Congress's objectives compelled a contrary interpretation. Instead, relying on dictum in *McVeigh*, 545 U.S. 677, the court declared FEHBA's preemption provision "ambiguous" and applied a presumption against preemption to resolve that putative ambiguity. Pet. App. 3a, 5a-7a, 47a-48a. That conclusion is incorrect because both of the state court's premises are wrong: The presumption against preemption has no application to FEHBA's preemption provision. In any event, Section 8902(m)(1) contains no genuine ambiguity that the presumption could resolve. *McVeigh* did not establish otherwise.

a. In both its 2014 and 2016 decisions, the Missouri Supreme Court commenced its "preemption analysis ... 'with the basic assumption that Congress did not intend to displace state law.'" Pet. App. 6a (citation omitted); *id.* at 47a-48a. That assumption has no place in construing FEHBA's preemptive scope.

The presumption against preemption is irrelevant because Section 8902(m)(1) is an *express*-preemption provision. Where a "statute 'contains an express pre-emption clause,'" courts "do *not* invoke any presumption against pre-emption," but "instead 'focus on the plain wording of the clause.'" *Franklin*, 136 S. Ct. at 1946 (emphasis added) (citation omitted). There is no reason to construe an express-preemption provision narrowly to avoid trenching inadvertently on state prerogatives; by definition, such provisions demonstrate that Congress *inten-*

tionally displaced state laws. The only question is *which* ones—and on that score, the statutory text is the best guide to Congress's intent. *See ibid.*

The presumption is independently inapposite because FEHBA addresses an area of overwhelmingly federal interests with a lengthy history of federal regulation. The presumption is merely a starting "assum[ption]" that, "[i]n areas of *traditional state regulation*," state law is not preempted "unless Congress has made such an intention 'clear and manifest.'" *Bates* v. *Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005) (emphasis added) (citation omitted). The presumption thus "is not triggered" in areas where the "interests at stake are 'uniquely federal' in nature," *Buckman Co.* v. *Plaintiffs' Legal Comm.*, 531 U.S. 341, 347 (2001) (citation omitted), or "where there has been a history of significant federal presence," *United States* v. *Locke*, 529 U.S. 89, 108 (2000); *see also Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016). Both are true of the provision of federal-employee benefits.

"[T]he relationship between a federal agency and the entity it regulates is inherently federal in character because the relationship originates from, is governed by, and terminates according to federal law." *Buckman*, 531 U.S. at 347. That is especially true of FEHBA, which "governs only contracts for the benefit of federal employees." *Helfrich*, 804 F.3d at 1105. Those contracts "concer[ning] benefits from a *federal* health insurance plan for *federal* employees that arise from a *federal* law" implicate "'[d]istinc[t] *federal* interests.'" *Bell*, 823 F.3d at 1202 (emphases added) (citation omitted). "The scope of a federal employee's reimbursement obligations," for instance, "has a significant impact on the federal treasury and

on premiums or benefits for other employees." *Ibid.*; *see* 5 U.S.C. § 8909(b); 5 C.F.R. § 890.503(c)(2). Even the decision below had "no doubt" that "regulating the provisions of health insurance benefits for federal employees" implicates a "strong federal interest." Pet. App. 12a. Given these overriding federal interests, "[t]he federalism concern (respecting state sovereignty) behind the presumption" thus "has little purchase" here. *Helfrich*, 804 F.3d at 1105.

It is also "an understatement to say that 'there has been a history of significant federal *presence*' in the area of federal employment" and federal-employee benefits. *Helfrich*, 804 F.3d at 1105 (emphasis added) (citation omitted). "Congress has legislated on the matter from the outset." *Ibid.* Congress *created* the FEHBA Program nearly six decades ago. The Program has been governed ever since by a federal statute and by regulations and contract terms prescribed by a federal agency. And from 1978 forward, *state* law has been explicitly displaced. Given this "obviously ... long history of federal involvement in federal employment and benefits," there is no basis to assume that, in preempting state law, Congress intended to tread lightly—and consequently no "warrant to place a thumb on the scales against [the] preemptive effect of" Section 8902(m)(1). *Bell*, 823 F.3d at 1202.

b. Even if the presumption against preemption did apply, it could not justify the Missouri Supreme Court's distortion of Section 8902(m)(1). The presumption is not a command to construe the preemptive reach of federal statutes narrowly at all costs. Even "[i]n areas of traditional state regulation" where it applies, the presumption is merely a tie-breaking tool for resolving ambiguities—a default

rule for selecting between otherwise-plausible interpretations of a statute's scope. *Bates*, 544 U.S. at 449. Where Congress "'*has* made [its] intention'" to preempt certain state laws "'clear and manifest,'" the presumption cannot override that intention. *Ibid.* (emphasis added) (citation omitted). Even "state laws 'governing'" issues of paradigmatic state concern—such as "family law"—"'must give way to clearly conflicting federal enactments,'" the presumption notwithstanding. *Hillman*, 133 S. Ct. at 1950 (citation omitted).

The presumption thus has no bearing on whether FEHBA preempts antisubrogation and antireimbursement laws because the statute speaks clearly; there is no tie to break. The only reading of Section 8902(m)(1) that is faithful to its text and purpose—and by far the most persuasive—is that it does supersede such laws. *Supra* pp. 23-35. Even if the Missouri Supreme Court's contrary reading were colorable, the presumption cannot elevate what is at best a barely tenable construction over a vastly more plausible reading of FEHBA's text and context.

Indeed, although the Missouri Supreme Court pronounced Section 8902(m)(1) "ambiguous" and subject to multiple "plausible readings," Pet. App. 3a, 47a-48a, it never undertook to demonstrate that its *own* interpretation is equally plausible. Instead, the court deemed Section 8902(m)(1) ambiguous based on dictum in *McVeigh*, 547 U.S. 677, and read that decision to require a narrow reading of FEHBA's preemptive scope. Pet. App. 3a-4a, 48a-51a. The Missouri Supreme Court badly misread *McVeigh*.

The only issue *McVeigh* decided concerned federal-court *jurisdiction* over FEHBA carriers' reimbursement actions—*i.e.*, "the proper *forum*" for

FEHBA carriers to seek reimbursement of duplicative benefits as their contracts require—not *whether* they may seek reimbursement despite state law. 547 U.S. at 682 (emphasis added). In *McVeigh*, a FEHBA carrier sued in federal court, seeking reimbursement from a participant who received plan benefits but also recovered from a third party. *Id.* at 683. The question presented in this Court was whether the carrier's claims "'ar[ose] under'" federal law so as to support jurisdiction under 28 U.S.C. § 1331. 547 U.S. at 683, 688 (citation omitted). Ordinarily, "[t]he presence or absence of federal-question jurisdiction" is judged based on the "face of the plaintiff's properly pleaded complaint," and "federal pre-emption is ... a defense." *Caterpillar Inc.* v. *Williams*, 482 U.S. 386, 392 (1987). But "the pre-emptive force of" some statutes "is so 'extraordinary'" that it not only displaces all state law in the field but also "'converts'" any purported state-law claim into a federal one, providing a federal forum for its adjudication. *Id.* at 393 (citations omitted). The carrier in *McVeigh* argued that its complaint "'state[d] a federal claim'" under this doctrine. 547 U.S. at 693 (citation omitted). Over the dissent of four Justices, the Court held federal jurisdiction lacking. *Id.* at 689-701; *cf. id.* at 702-14 (Breyer, J., joined by Kennedy, Souter, and Alito, JJ., dissenting).

In addressing that jurisdictional issue, the majority noted two alternative interpretations of Section 8902(m)(1) advanced principally by two *amici*. 547 U.S. at 697. The United States urged that reimbursement is a "condition or limitation on benefits received by a federal employee," and therefore does relate to "'coverage or benefits' and 'payments with respect to benefits.'" *Ibid.* (citing U.S. *Amicus* Br. 20, *McVeigh*, No. 05-200 (U.S. Feb. 24, 2006), 2006 WL

467692). An *amicus* supporting the FEHBA-plan participant, in contrast, asserted that "'coverage' and 'benefits'" refer only to "contract terms relating to the beneficiary's entitlement (or lack thereof) to Plan payment for certain healthcare services," but "not to terms relating to the carrier's postpayment right to reimbursement." *Ibid.* (citing Julia Cruz *Amicus* Br. 10-11, *McVeigh*, No. 05-200 (Mar. 31, 2006), 2006 WL 927237).

After noting these two proffered interpretations, *McVeigh* expressly reserved judgment on them because they had no bearing on the jurisdictional question. 547 U.S. at 698. "To decide this case," the Court explained, it "need not choose between those plausible constructions," because federal jurisdiction would not exist *either way*: Regardless of whether FEHBA preempts state laws restricting reimbursement and subrogation, it does not create a freestanding federal cause of action. *Ibid.* The Court accordingly undertook no analysis of which reading of Section 8902(m)(1) is more faithful to its text, Congress's purpose, and this Court's precedent; there was no need. Instead, consistent with the well-settled "dictate of wisdom and judicial propriety to decide no more than is necessary to the case in hand," *Trade-Mark Cases*, 100 U.S. 82, 96 (1879); *see also, e.g.*, *Samsung Elecs. Co.* v. *Apple Inc.*, __ U.S. __, 2016 WL 7078449, at *6 (Dec. 6, 2016), the Court expressed no opinion on Section 8902(m)(1)'s scope. It merely described two competing constructions advocated by litigants, and explained their irrelevance to the question presented.

Properly understood, *McVeigh* does not establish anything about the correct interpretation of Section 8902(m)(1)—as other courts have consistently recog-

nized, *see, e.g.*, *Bell*, 823 F.3d at 1203; *López-Muñoz* v. *Triple-S Salud, Inc.*, 754 F.3d 1, 6 (1st Cir. 2014); *Pellicano* v. *Blue Cross Blue Shield Ass'n*, 540 F. App'x 95, 98-99 (3d Cir. 2013) (per curiam). The Court did not hold that FEHBA's preemption provision is ambiguous at all. Even read for all it might be worth, *McVeigh*'s passing description in dictum of competing interpretations as "plausible" in the abstract hardly justifies declaring Section 8902(m)(1)'s words a wash and invoking the presumption against preemption to pick the narrower reading. "[T]o acknowledge ambiguity is not to conclude that all interpretations are *equally* plausible." *Gwaltney of Smithfield, Ltd.* v. *Chesapeake Bay Found., Inc.*, 484 U.S. 49, 57 (1987) (emphasis added). *McVeigh* certainly did not hold that the two interpretations the Court described are in equipoise. Even if the Missouri Supreme Court's reading of FEHBA were in the ballpark (and it is not), the statute's text and Congress's readily apparent purpose point decidedly in favor of preemption.

B. OPM's Reasonable Interpretation Of FEHBA Controls Under *Chevron*.

OPM's 2015 regulation construing FEHBA to preempt state antisubrogation and antireimbursement laws independently compels adopting that construction here and reversing the decision below. Indeed, although OPM's statutory interpretation is correct, to decide this case the Court need not determine whether any other constructions are also (or even equally) plausible. Regardless of whether FEHBA is clear or ambiguous, all that matters under this Court's precedent is that OPM's reading of a statute it administers is *reasonable*. OPM's interpretation easily clears that threshold, and therefore controls.

The Missouri Supreme Court expressly refused to defer to OPM's interpretation of FEHBA. But it did not dispute that OPM's reading is reasonable. The court withheld deference instead based on the mistaken premise that *Chevron* is categorically inapplicable to preemption clauses in federal statutes. This Court's case law refutes that misunderstanding.

1. OPM's Interpretation Of FEHBA Is Reasonable And Merits Deference.

It is blackletter law that a federal agency's reasonable interpretation of a federal statute it administers governs under *Chevron*, 467 U.S. at 843-44, at least when articulated through "administrative action with the effect of law," such as "notice-and-comment rulemaking," *United States* v. *Mead Corp.*, 533 U.S. 218, 230 (2001). Congress may "express[ly] delegat[e]" an issue to an agency's discretion, or may do so "implicit[ly]," by not addressing the issue directly in the statute's text. *Chevron*, 467 U.S. at 843-44. Either way, "a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Id.* at 844. When Congress "le[aves] ambiguity in a statute," courts "presum[e]" Congress "understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows." *Smiley*, 517 U.S. at 740-41. The agency's "view governs if it is a reasonable interpretation of the statute"—whether or not it is "the only possible interpretation," or "even the interpretation deemed *most* reasonable by the courts." *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 (2009). That applies to "*all* the matters the agency is

charged with administering." *City of Arlington*, 133 S. Ct. at 1874.

Straightforward application of *Chevron* resolves this case. Congress authorized OPM to administer FEHBA by "prescrib[ing] regulations necessary to carry out" the statute, 5 U.S.C. § 8913(a), and by establishing "definitions of benefits," including "limitations" and "exclusions," in its contracts, *id.* § 8902(d). OPM articulated its position in a notice-and-comment rule carrying the force of law, which speaks directly to the question here. *Final Rule*, 80 Fed. Reg. at 29,204-05 (Pet. App. 167a). It provides that "[a]ny FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage"—thus defining benefits as subject to this condition. 5 C.F.R. § 890.106(b)(1). It concludes that "[a] carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1)"—and that those "rights and responsibilities are therefore effective notwithstanding any state or local law." *Id.* § 890.106(h).

Under *Chevron*, OPM's interpretation controls so long as it is "reasonable." *Entergy*, 556 U.S. at 218 & n.4. This Court, in fact, need not even decide whether FEHBA unambiguously compels OPM's interpretation, or instead might plausibly bear some other reading; so long as the interpretation *OPM* has adopted is at least "reasonable," it "governs." *Ibid.*

There is not, and cannot be, any serious dispute that OPM's interpretation of Section 8902(m)(1) is at least reasonable. OPM's position is by far the most persuasive reading of FEHBA's plain language, and the only interpretation faithful to Congress's purposes. *Supra* pp. 23-35. Both the decision below and Nevils *conceded* that OPM's reading of FEHBA's text is "plausible." Pet. App. 3a; Nevils Mo. S. Ct. Br. 31, 36 (Oct. 6, 2015). And neither disputed that OPM's interpretation is otherwise consistent with Congress's "expressed intent." *Rust* v. *Sullivan*, 500 U.S. 173, 184 (1991) (agency's position is entitled to *Chevron* deference "if it reflects a plausible construction of the plain language of the statute and does not otherwise conflict with Congress' expressed intent").

OPM's experience and expertise administering the Program bolster the reasonableness of its interpretation. "As the agency that has negotiated FEHBA contracts for federal employees for years, OPM has deep knowledge of the impact and interrelationships of contractual provisions." *Helfrich*, 804 F.3d at 1109-10. The agency is particularly well-positioned to assess the adverse effects of allowing state antisubrogation and antireimbursement laws to interfere with FEHBA contracts.

The consistency of OPM's position over many years entitles it to still greater weight. While *Chevron* applies regardless of when OPM first adopted the position reflected in its regulation (or even if it previously had taken a different view), *see Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 981 (2005), the "consisten[cy]" of OPM's interpretation and "[t]he length of time" it has maintained that position reinforce its reasonableness. *Kasten*, 563 U.S. at 15-16. OPM's 2015

regulation codifies the agency's "longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978." *Final Rule*, 80 Fed. Reg. at 29,204 (Pet. App. 162a). OPM "has consistently taken the position that the FEHB Act preempts state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts." *Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 153a); *see also* 2012 Carrier Letter 1-2 (Pet. App. 116a-18a).

Indeed, even *before* Congress enacted FEHBA's express-preemption provision, OPM's predecessor, the Civil Service Commission, made clear its view that "'the Federal Employees Health Benefits Act preempts state laws in this area.'" H.R. Rep. No. 95-282, at 3 (J.A.354) (citation omitted). Concerned that the absence of an express-preemption provision would make "'enforcement of this preemption policy'" both "'time consuming and costly,'" *ibid.* (citation omitted), and to ensure the agency had "clear authority to issue regulations" addressing the scope of preemption, Congress enacted Section 8902(m)(1) in 1978. S. Rep. No. 95-903, at 4 (J.A.370). OPM, created the same year, has understood the statute ever since to preempt state antisubrogation and antireimbursement laws. *Final Rule*, 80 Fed. Reg. at 29,204 (Pet. App. 162a).

OPM's interpretation of FEHBA in its regulation is at a minimum reasonable. It therefore merits dispositive deference under *Chevron*. *See Kobold* v. *Aetna Life Ins. Co.*, 370 P.3d 128, 130-32 (Ariz. Ct. App. 2016), *review denied*, No. CV-16-0082-PR (Ariz. Oct. 19, 2016). Even if OPM's regulation did not merit full-fledged *Chevron* deference, it still would be entitled to significant weight, given OPM's

"longstanding and persuasively explained" reading, *Helfrich*, 804 F.3d at 1109-10, and its "'experience and informed judgment'" administering FEHBA, *Fed. Exp. Corp.* v. *Holowecki*, 552 U.S. 389, 399 (2008) (quoting *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 139-40 (1944); other citation omitted); *see Helfrich*, 804 F.3d at 1109-10 & n.11 ("we would adopt OPM's conclusion" "even under [*Skidmore*'s] less deferential standard"). The respect due to OPM's expert, longstanding position resolves any possible ambiguity FEHBA might be read to contain.

2. The Missouri Supreme Court Had No Basis To "Decline" To Apply *Chevron*.

The Missouri Supreme Court refused to accord OPM's position *any* weight. Pet. App. 5a-12a, 54a n.2. It asserted that *this* Court "has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause," and, in the "[a]bsen[ce]" of "binding precedent *requiring* such deference," it "decline[d]" to apply *Chevron* in construing Section 8902(m)(1). *Id.* at 5a (emphasis added). In the state court's view, *Chevron* could not overcome the presumption against preemption that the court held applicable. That invented carve-out from *Chevron* is irreconcilable with this Court's case law.

a. This Court has flatly rejected the assertion that *Chevron* applies piecemeal to some topics under a statute but not others. *See City of Arlington*, 133 S. Ct. at 1874. Where an agency is authorized to interpret a statute, "the whole includes all of its parts," and *Chevron* "validate[s] rules for *all* the matters the agency is charged with administering." *Ibid.* There are "no 'exception[s]'" to *Chevron*, this

Court made clear, for any "'legal questions concerning the coverage' of an Act." *Id.* at 1871 (brackets and citation omitted). Indeed, there has not been "a single case" in which a court held "a general conferral" of rulemaking authority "insufficient to support *Chevron* deference for an exercise of that authority within the agency's substantive field." *Id.* at 1874. "[T]he preconditions to deference under *Chevron* are satisfied," in short, so long as "Congress has unambiguously vested [an agency] with general authority to administer [the statute] through rulemaking ... , and the agency interpretation at issue was promulgated in the exercise of that authority." *Ibid.*

City of Arlington forecloses creating any exception to *Chevron* here. FEHBA explicitly authorizes OPM to "prescribe regulations necessary to carry out this chapter"—*viz.*, Chapter 89 of Title 5, the entirety of FEHBA. 5 U.S.C. § 8913(a). That authorization empowered OPM to interpret *every* aspect of the statute—including Section 8902(m)(1).

The Missouri Supreme Court dismissed *City of Arlington* as "not a Supremacy Clause case." Pet. App. 11a. But the case concerned the Federal Communications Commission's interpretation of a federal statute that places restrictions on the regulatory authority of *state and local governments*—several of which were petitioners in this Court. 133 S. Ct. at 1866-67. Indeed, the Court specifically noted that it had previously "deferred to the FCC's assertion that its broad regulatory authority extends to preempting conflicting state rules." *Id.* at 1871. More fundamentally, *City of Arlington*'s central holding is that there are *no* subject-matter-specific exceptions to *Chevron*. *Id.* at 1868-75. The Missouri Supreme

Court's attempt to limit that case to a particular topical area eviscerates that holding.

b. This Court's decisions, moreover, have repeatedly made clear that *Chevron* applies to the interpretation of preemption provisions specifically. The court below distorted or disregarded those decisions.

i. In *Smiley*, this Court expressly held that *Chevron* applies to an agency's interpretation of the "meaning" of a provision that "pre-empts state law." 517 U.S. at 744. *Smiley* concerned a regulation issued by the Comptroller of the Currency construing a provision of the National Bank Act, 12 U.S.C. § 85. The Court had previously held (in *Marquette National Bank of Minneapolis* v. *First of Omaha Service Corp.*, 439 U.S. 299 (1978)) that Section 85 preempted state laws limiting the maximum interest rates that national banks may charge their credit-card customers. *See Smiley*, 517 U.S. at 737, 744. The question in *Smiley* concerned the *extent* of that preemption.

Smiley held that the Comptroller's interpretation of the statute's preemptive scope merited *Chevron* deference. The Comptroller was "'charged with the enforcement of banking laws to an extent that warrants the invocation of the rule of deference with respect to his deliberative conclusions as to the meaning of these laws.'" 517 U.S. at 739 (brackets and citation omitted). The statute included a general grant of authority, closely similar to FEHBA's provision, to prescribe regulations implementing the federal banking laws. 12 U.S.C. § 93a (1996); *see also id.* § 1 (1996). Exercising that authority, the Comptroller issued a regulation construing the term "'interest'" in Section 85 to include "late-payment fees" that

banks charged credit-card customers. *Smiley*, 517 U.S. at 737, 740.

This Court unanimously held that the Comptroller's interpretation was "reasonable" and therefore "entitled to deference" under *Chevron*—*even though* it had the effect of determining the extent to which state laws were preempted. 517 U.S. at 745-47. The Court reserved judgment on whether *Chevron* applies to "the question of *whether* a statute is pre-emptive"—*i.e.*, whether it displaces *any* state laws—because "there [was] no doubt that § 85 pre-empts state law" to *some* extent, given this Court's prior precedent in *Marquette*. *Id.* at 744. The only dispute in *Smiley* concerned the "substantive ... *meaning* of [the] statute," *i.e.*, *which* state laws were preempted. *Ibid.* On *that* issue, *Smiley* held, *Chevron* applies with full force. *Ibid.* So long as the agency's interpretation of the statute's "meaning" is "a reasonable one," it controls, whether or not a court believes that "it represents the best interpretation." *Id.* at 744-45.

That is precisely the case here. As in *Smiley*, "there is no doubt that" FEHBA "pre-empts state law" to *some* extent. 517 U.S. at 744. Section 8902(m)(1) explicitly "supersede[s] and preempt[s]" some state laws. 5 U.S.C. § 8902(m)(1). The only dispute is *which* state laws. OPM's reasonable conclusion on that question concerns FEHBA's "substantive ... *meaning*," and so is "entitled to deference" under *Chevron*. *Smiley*, 517 U.S. at 744, 747.

The Missouri Supreme Court misread *Smiley* as "indicat[ing] that *Chevron* deference does *not* apply to provisions ... that deal expressly with preemption." Pet. App. 9a (emphasis added). Seizing on *Smiley*'s distinction between the "substantive" versus the "pre-emptive" meaning of a statute, the decision

below deemed *Chevron* categorically inapplicable to express-preemption provisions. *Ibid.* That reading turns *Smiley*'s holding upside-down. *Smiley*'s central point was that, where a statute unambiguously does preempt some laws, the extent of preemption is a question of its "substantive ... meaning," to which the *Chevron* framework *does* apply. 517 U.S. at 744. Indeed, the statute in *Smiley* was indistinguishable from an express-preemption provision; as *Smiley* came to this Court, it already was settled—by this Court's decision in *Marquette*—that the statute preempted some laws. *Ibid.* Given this Court's unanimous holding that *Chevron* applied to *that* statute, it makes no sense to withhold deference with respect to an agency's reading of a statute that on its face preempts state law.

ii. This Court's decisions since *Smiley* confirm that *Chevron* applies to an agency's reasonable interpretation of the *scope* of a statute that expressly preempts state law.

Only weeks after *Smiley*, in *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470 (1996), this Court deferred under *Chevron* to a Food and Drug Administration ("FDA") regulation addressing the scope of the express-preemption provision of the Medical Device Amendments to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 360k(a). 518 U.S. at 496-97. The FDA had construed that statute not to "'preempt [certain] State or local requirements'"—namely, those that are "'equal'" or "'identical'" to requirements imposed by the statute or the FDA. *Ibid.* (citation omitted). Invoking *Chevron*, the Court deferred to that reading. *Id.* at 496. "The ambiguity in the statute—and the congressional grant of authority to the agency on the matter contained within it—provide a 'sound basis'

for giving substantial weight to the agency's view of the statute." *Ibid.* (citations omitted). The FDA "is the federal agency to which Congress has delegated its authority to implement the provisions of the Act," and it is "uniquely qualified to determine whether a particular form of state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress'"—and "therefore, whether [state law] should be pre-empted." *Ibid.* (citation omitted). Although Coventry and the United States brought *Medtronic* to the Missouri Supreme Court's attention, that court never addressed *Medtronic*'s relevant holding applying *Chevron*.

More recently, the Court held in *Cuomo* v. *Clearing House Association, LLC*, 557 U.S. 519 (2009), that "the familiar *Chevron* framework" applied to another express-preemption provision. *Id.* at 525. Like *Smiley*, *Clearing House* involved a regulation issued by the Comptroller of the Currency concerning the preemptive scope of a provision of the National Bank Act, this one concerning the "visitorial powers" of state regulators over national banks. *Id.* at 524-25. The Court explained that the Comptroller, "charged with administering" the statute, is entitled under *Chevron* to "give authoritative meaning to the statute within the bounds of [the statute's] uncertainty." *Id.* at 525. "The question presented" was therefore "whether the Comptroller's regulation purporting to pre-empt state law enforcement can be upheld as a reasonable interpretation of the National Bank Act." *Id.* at 523-24. The Court did not defer to the Comptroller's regulation only because the agency's interpretation of the statute in its regulation contradicted the statute's "clear" meaning. *Id.* at 525. The relevant statute contained some ambiguity, but the "Comptroller's expansive regulation" had

strayed far beyond the "outer limits" of that ambiguity. *Ibid.*

Here too, however, the decision below dodged this Court's relevant holding. It wrote off *Clearing House* because this Court did not ultimately accept the agency's reading of the specific statute. Pet. App. 11a-12a. But the Missouri Supreme Court had no answer to this Court's explicit holding that "the familiar *Chevron* framework" *applied*. 557 U.S. at 525.

c. Even if the Missouri Supreme Court were correct that this Court had never "expressly held" *Chevron* applicable to interpreting preemption provisions, it offered no valid reason why, as an original matter, *Chevron* should not apply. The decision below appeared to reason that the presumption against preemption superseded *Chevron*. *See* Pet. App. 6a-10a. But that presumption has no proper application to FEHBA's preemption provision. *Supra* pp. 36-42. And even if the presumption were otherwise applicable, elevating it over ordinary principles of administrative deference further contravenes this Court's teaching, and would create an illogical anomaly in federal law.

Smiley specifically confronted and rejected the assertion that "'the presumption against ... pre-emption' ... in effect trumps *Chevron*" in construing the scope of a preemption provision. 517 U.S. at 743 (citation omitted). The petitioner in *Smiley* urged that "*no* Comptroller interpretation of § 85" of the National Bank Act "is entitled to deference, because § 85 is a provision that preempts state law," and that the presumption "requires a court to make its own interpretation of" the statute "that will avoid (to the extent possible) pre-emption of state law." *Id.* at 743-44. "This argument," the Court held, "confuses

the question of the substantive (as opposed to pre-emptive) *meaning* of a statute with the question of *whether* a statute is pre-emptive." *Id.* at 744. "[A]ssuming (without deciding) that the latter question must always be decided *de novo* by courts," *Smiley* held that an agency's position on the *former* question—the scope, *i.e.*, the "*meaning*," of a statute that undisputedly preempts some state laws—"deserves deference" under *Chevron*, irrespective of the presumption. *Ibid.*

The Missouri Supreme Court's contrary view, moreover, would perversely mean that federal agencies have *less* authority to deem state laws preempted when Congress *explicitly* displaces state law than in administering statutes that do *not* address preemption. This Court has long held that regulations issued by an agency acting within its authority "have no less preemptive effect than federal statutes." *Capital Cities Cable, Inc.* v. *Crisp*, 467 U.S. 691, 699 (1984) (quoting *Fid. Fed. Sav. & Loan Ass'n* v. *de la Cuesta*, 458 U.S. 141, 153-54 (1982)). "Where Congress has directed an administrator to exercise his discretion, his judgments"—concerning preemption no less than other subjects—"are subject to judicial review only to determine whether he has exceeded his statutory authority or acted arbitrarily." *Ibid.* (citation omitted). Thus, "in the area of pre-emption, if the agency's choice to pre-empt 'represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute, [courts] should not disturb it unless it appears from the statute or its legislative history that the accommodation is not one that Congress would have sanctioned.'" *City of New York* v. *FCC*, 486 U.S. 57, 64 (1988) (citation omitted); *see also City of Arlington*, 133 S. Ct. at 1871. And evaluating

whether the agency is "'acting within the scope of its congressionally delegated authority' ... does *not* involve a 'presumption against pre-emption.'" *New York* v. *FERC*, 535 U.S. 1, 18 (2002) (emphasis added) (citation omitted). Courts simply "interpret the statute to determine whether Congress has given [the agency] the power to act as it has ... without any presumption one way or the other." *Ibid.*

If Section 8902(m)(1) did not exist, therefore, and if OPM had promulgated its regulation preempting state antisubrogation and antireimbursement laws simply as an exercise of its statutory authorization to "prescribe regulations necessary to carry out" FEHBA, 5 U.S.C. § 8913(a), there would be no question that OPM's determination is entitled to deference. Its regulation would be reviewable only to determine whether OPM "exceeded [its] statutory authority or acted arbitrarily." *Capital Cities*, 467 U.S. at 699. And no presumption against preemption would apply. *See New York*, 535 U.S. at 18. Yet on the Missouri Supreme Court's view, OPM's determination deserves *no* deference—and the presumption against preemption *does* apply—because Congress *explicitly* preempted state laws, and OPM's regulation construed the scope of that express-preemption provision. That irrational result is not and cannot be the law.

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Whether as an original matter of statutory interpretation or as a straightforward application of *Chevron*, the correct reading of FEHBA is the same: The statute preempts state laws preventing carriers from seeking subrogation and reimbursement under their FEHBA contracts.

II. FEHBA'S EXPRESS-PREEMPTION PROVISION COMPORTS WITH THE SUPREMACY CLAUSE.

The Missouri Supreme Court alternatively held that FEHBA does not preempt state laws barring subrogation and reimbursement for a second reason: The six concurring judges opined that Section 8902(m)(1) violates the Supremacy Clause, and so presumably preempts *nothing*. Pet. App. 14a. Under Missouri law, that "concurring opinion" in which "a majority of the court concurred" also constitutes a precedential holding of the court. *Mueller* v. *Burchfield*, 224 S.W.2d 87, 89 (Mo. 1949); *accord State ex rel. Bothwell* v. *Green*, 180 S.W.2d 12, 13 (Mo. 1944). That alternative, constitutional holding is unsustainable.

The Supremacy Clause provides that "the Laws of the United States which shall be made in Pursuance [of the Constitution] ... shall be the supreme Law of the Land; ... any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. FEHBA's preemption provision is perfectly consistent with that constitutional imperative. Section 8902(m)(1) *itself* declares that the state and local laws it covers are "supersede[d] and preempt[ed]." 5 U.S.C. § 8902(m)(1). It is thus the *statute* Congress enacted—one of "the Laws of the United States ... made in Pursuance" of the Constitution, U.S. Const. art. VI, cl. 2—that displaces state law. That is all the Supremacy Clause requires.

Adopting the reasoning of Judge Wilson's prior concurrence in *Nevils I* (Pet. App. 66a-72a), however, the six-judge concurrence below held that Section 8902(m)(1) is invalid because it improperly "attempt[s] to give preemptive effect to the provisions of

a contract between the federal government and a private party." *Id.* at 14a. That conclusion is untenable. It is Section 8902(m)(1) itself, by its express terms, that declares state laws "supersede[d] and preempt[ed]," to make room for FEHBA contracts to operate. That Section 8902(m)(1) defines the *scope* of the laws FEHBA preempts partly by reference to OPM's contracts is immaterial. The fact remains that *Congress*, in a duly enacted statute, decided to preempt state law, and to what extent.

FEHBA's approach of defining the extent of preemption by reference to contracts, in fact, is unremarkable. Congress prescribes the scope of preemption in a variety of ways. Sometimes it supersedes all state laws on a topic. *See, e.g.*, *Morales*, 504 U.S. at 383 (applying statute that preempted "'any law, rule, regulation, standard, or other provision ... relating to rates, routes, or services of any air carrier'" (quoting 49 U.S.C. app. § 1305(a)(1) (1988))). In other contexts, Congress preempts state laws that differ from or add to requirements in specific statutes. *See, e.g.*, *Riegel* v. *Medtronic, Inc.*, 552 U.S. 312, 316 (2008) (applying 21 U.S.C. § 360k(a), which preempts any state-law requirement "which is different from, or in addition to, any requirement" under certain federal statutes if it "relates to the safety or effectiveness of" a medical device).

Congress also can and does enact statutes that expressly preempt state laws that relate to a particular type of contracts or other instruments. In the context of federal-employee benefits, such provisions are commonplace. The statute in *Hillman*, for instance, preempts state laws "'inconsistent with'" the terms of "'any contract under'" federal law governing federal life-insurance benefits. 133 S. Ct. at 1948

(quoting 5 U.S.C. § 8709(d)(1)). Other statutes preempt state laws that are inconsistent with "[t]he terms of any contract that relate to the nature, provision, or extent of coverage or benefits" for federal dental, vision, long-term-care, and military service-member benefits. 5 U.S.C. §§ 8959, 8989, 9005(a); *see also* 10 U.S.C. § 1103(a). Statutes outside the federal-employee-benefits context follow the same approach. ERISA, for example, expressly preempts "'any and all State laws insofar as they ... relate to any employee benefit plan.'" *FMC*, 498 U.S. at 57 (quoting 29 U.S.C. § 1144(a)). And the Federal Arbitration Act limits the grounds for denying enforcement of any "written provision in any ... contract" providing for arbitration—thus preempting state laws that would otherwise interfere with arbitration agreements. 9 U.S.C. § 2.

If the Missouri Supreme Court were correct that FEHBA's reference to contracts violated the Supremacy Clause, then *all* of these statutes tethering the scope of preemption to contract terms would be unconstitutional as well. In reality, all of these provisions comply with the Clause for the same reason FEHBA does: In each instance, as in Section 8902(m)(1), it is the *statute*—not the categories of contracts it identifies—that preempts state law.

Indeed, FEHBA is on even surer constitutional footing than ERISA or the Federal Arbitration Act—both of which this Court has repeatedly held preempt state laws, *see, e.g.*, *Gobeille*, 136 S. Ct. at 942-47; *Marmet Health Care Ctr., Inc.* v. *Brown*, 132 S. Ct. 1201, 1203-04 (2012) (per curiam). Unlike those statutes, which tie the scope of preemption to purely *private* contracts, FEHBA prevents state laws from frustrating contracts made with a federal agency,

pursuant to a federal statute, for the operation of a federal-government program. 5 U.S.C. § 8902(a), (m)(1). States' authority to interfere with such contracts would be sharply limited even in the absence of an express-preemption provision. *See Clearfield Tr. Co.* v. *United States*, 318 U.S. 363, 366 (1943); *cf. Boyle* v. *United Techs. Corp.*, 487 U.S. 500, 507-09 (1988). Congress assuredly has authority to prevent state-law interference with such contracts explicitly.

The Missouri Supreme Court's constitutional concern, in short, is eliminated by sensibly construing Section 8902(m)(1) as giving preemptive effect to federal law—not contracts themselves. That is by far the best reading of FEHBA's text in context. And it is how OPM has long construed the statute. *See Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 153a) ("OPM has consistently taken the position that *the FEHB Act preempts* state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts" (emphasis added)).

At a bare minimum, the statute *can* fairly be read in that fashion, and therefore it *must* be so interpreted to avoid any constitutional concern. "'[T]he elementary rule is that every reasonable construction must be resorted to, in order to save a statute from unconstitutionality.'" *Edward J. DeBartolo Corp.* v. *Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988) (citation omitted). Thus, "where an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress." *Ibid.*

As the Second Circuit explained in the decision affirmed in *McVeigh*, Section 8902(m)(1) can be "rea-

sonably construe[d] ... as requiring that, in cases involving the 'terms of any contract under [FEHBA] which relate to the nature, provision, or extent of coverage or benefits,' *federal law* 'shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.'" *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 396 F.3d 136, 144-45 (2d Cir. 2005) (Sotomayor, J.) (alteration in original) (citation omitted), *aff'd*, 547 U.S. 677. That interpretation obviates any possible constitutional concern, and it is "faithful ... to [Section 8902(m)(1)'s] plain language and respects Congress's stated intent to maintain 'uniformity' in FEHBA benefits and to 'displace State or local law relating to health insurance or plans.'" *Ibid.* (citation omitted). Even the dissent agreed on this point, *id.* at 156 (Raggi, J., dissenting), as have other courts to consider the issue. *See Bell*, 823 F.3d at 1204; *Kobold*, 370 P.3d at 131 n.2.

Rather than construe FEHBA sensibly to avoid any constitutional question, however, the Missouri Supreme Court skewed the statute to *create* one. The concurring judges (adopting Judge Wilson's analysis in *Nevils I*) specifically rejected a construction of FEHBA that comports with the Supremacy Clause, and insisted on interpreting Section 8902(m)(1) as "giv[ing] preemptive effect to the provisions of a contract." Pet. App. 14a, 70a-71a. That conclusion invalidates Section 8902(m)(1) *in toto*. If upheld, it would mean that FEHBA's express-preemption provision actually preempts *nothing*. The result would be open season for state-law interference with the FEHBA Program. *Every* aspect of FEHBA contracts, which provide benefits for millions of federal workers and dependents, would be at risk of regulation by a patchwork of state laws—even

those provisions, including subrogation and reimbursement terms, that federal regulations *require* FEHBA contracts to contain, 5 C.F.R. § 890.106(a); *see also Kobold*, 370 P.3d at 131 n.2.

The Missouri Supreme Court's strained statutory interpretation, which causes rather than averts a constitutional conflict, has nothing to commend it. And there is more than ample reason to reject it. This Court should hold that FEHBA itself validly preempts state law—including laws, like Missouri's, that prevent FEHBA carriers from fulfilling their contractual obligations to the federal government to seek subrogation and reimbursement recoveries.

CONCLUSION

The Missouri Supreme Court's judgment should be reversed.

Respectfully submitted.

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APPENDIX

APPENDIX

(All provisions reflect current text except where otherwise indicated.)

U.S. Const. art. VI, cl. 2

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

5 U.S.C. § 8709. Insurance policies

(a) The Office of Personnel Management, without regard to section 6101(b) to (d) of title 41, may purchase from one or more life insurance companies a policy or policies of group life and accidental death and dismemberment insurance to provide the benefits specified by this chapter. A company must meet the following requirements:

(1) It must be licensed to transact life and accidental death and dismemberment insurance under the laws of 48 of the States and the District of Columbia.

(2) It must have in effect, on the most recent December 31 for which information is available to the Office, an amount of employee group life insurance equal to at least 1 percent of the total amount of employee group life insurance in the United States in all life insurance companies.

(b) A company issuing a policy under subsection (a) of this section shall establish an administrative office under a name approved by the Office.

(c) The Office at any time may discontinue a policy purchased from a company under subsection (a) of this section.

(d) (1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any law of any State or political subdivision thereof, or any regulation issued thereunder, which relates to group life insurance to the extent that the law or regulation is inconsistent with the contractual provisions.

(2) For the purpose of this section, "State" means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and a territory or possession of the United States.

5 U.S.C. § 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) an employee as defined by section 2105 of this title;

(B) a Member of Congress as defined by section 2106 of this title;

(C) a Congressional employee as defined by section 2107 of this title;

(D) the President;

(E) an individual first employed by the government of the District of Columbia before October 1, 1987;

(F) an individual employed by Gallaudet College;[1]

(G) an individual employed by a county committee established under section 590h(b) of title 16;

(H) an individual appointed to a position on the office staff of a former President under section 1(b) of the Act of August 25, 1958 (72 Stat. 838);

(I) an individual appointed to a position on the office staff of a former President, or a former Vice President under section 5 of the Presidential Transition Act of 1963, as amended (78 Stat. 153), who immediately before the date of such appointment was an employee as defined under any other subparagraph of this paragraph; and

(J) an individual who is employed by the Roosevelt Campobello International Park Commission and is a citizen of the United States,

but does not include—

(i) an employee of a corporation supervised by the Farm Credit Administration if private interests elect or appoint a member of the board of directors;

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[1] See Change of Name note below.

(ii) an individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter on September 30, 1979, by reason of service in an Executive agency, the United States Postal Service, or the Smithsonian Institution in the area which was then known as the Canal Zone;

(iii) an employee of the Tennessee Valley Authority; or

(iv) an employee excluded by regulation of the Office of Personnel Management under section 8913(b) of this title;

(2) "Government" means the Government of the United States and the government of the District of Columbia;

(3) "annuitant" means—

(A) an employee who retires—

(i) on an immediate annuity under subchapter III of chapter 83 of this title, or another retirement system for employees of the Government, after 5 or more years of service;

(ii) under section 8412 or 8414 of this title;

(iii) for disability under subchapter III of chapter 83 of this title, chapter 84 of this title, or another retirement system for employees of the Government; or

(iv) on an immediate annuity under a retirement system established for employees described in section 2105(c), in the case of an individual who elected under section 8347(q)(2) or 8461(n)(2) to remain subject to such a system;

(B) a member of a family who receives an immediate annuity as the survivor of an employee (including a family member entitled to an amount under section 8442(b)(1)(A), whether or not such family member is entitled to an annuity under section 8442(b)(1)(B)) or of a retired employee described by subparagraph (A) of this paragraph;

(C) an employee who receives monthly compensation under subchapter I of chapter 81 of this title and who is determined by the Secretary of Labor to be unable to return to duty; and

(D) a member of a family who receives monthly compensation under subchapter I of chapter 81 of this title as the surviving beneficiary of—

(i) an employee who dies as a result of injury or illness compensable under that subchapter; or

(ii) a former employee who is separated after having completed 5 or more years of service and who dies while receiving monthly compensation under that subchapter and who has been held by the Secretary to have been unable to return to duty;

(4) "service", as used by paragraph (3) of this section, means service which is creditable under subchapter III of chapter 83 or chapter 84 of this title;

(5) "member of family" means the spouse of an employee or annuitant and an unmarried dependent child under 22 years of age, including—

(A) an adopted child or recognized natural child; and

(B) a stepchild or foster child but only if the child lives with the employee or annuitant in a regular parent-child relationship;

or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

(6) "health benefits plan" means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization and an association of organizations or other

entities described in this paragraph sponsoring a health benefits plan;

(8) "employee organization" means—

(A) an association or other organization of employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter and which, after December 31, 1978, and before January 1, 1980, applied to the Office for approval of a plan provided under section 8903(3) of this title; and

(B) an association or other organization which is national in scope, in which membership is open only to employees, annuitants, or former spouses, or any combination thereof, and which, during the 90-day period beginning on the date of enactment of section 8903a of this title, applied to the Office for approval of a plan provided under such section;

(9) "dependent", in the case of any child, means that the employee or annuitant involved is either living with or contributing to the support of such child, as determined in accordance with such regulations as the Office shall prescribe;

(10) "former spouse" means a former spouse of an employee, former employee, or annuitant—

(A) who has not remarried before age 55 after the marriage to the employee, former employee, or annuitant was dissolved,

(B) who was enrolled in an approved health benefits plan under this chapter as a family member at any time during the 18-

month period before the date of the dissolution of the marriage to the employee, former employee, or annuitant, and

(C) (i) who is receiving any portion of an annuity under section 8345(j) or 8467 of this title or a survivor annuity under section 8341(h) or 8445 of this title (or benefits similar to either of the aforementioned annuity benefits under a retirement system for Government employees other than the Civil Service Retirement System or the Federal Employees' Retirement System),

(ii) as to whom a court order or decree referred to in section 8341(h), 8345(j), 8445, or 8467 of this title (or similar provision of law under any such retirement system other than the Civil Service Retirement System or the Federal Employees' Retirement System) has been issued, or for whom an election has been made under section 8339(j)(3) or 8417(b) of this title (or similar provision of law), or (iii) who is otherwise entitled to an annuity or any portion of an annuity as a former spouse under a retirement system for Government employees,

except that such term shall not include any such unremarried former spouse of a former employee whose marriage was dissolved after the former employee's separation from the service (other than by retirement); and

(11) "qualified clinical social worker" means an individual—

(A) who is licensed or certified as a clinical social worker by the State in which such individual practices; or

(B) who, if such State does not provide for the licensing or certification of clinical social workers—

(i) is certified by a national professional organization offering certification of clinical social workers; or (ii) meets equivalent requirements (as prescribed by the Office).

5 U.S.C. § 8902(m)(1). Contracting authority (1982)

* * *

(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

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5 U.S.C. § 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 6101(b) to (d) of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k) (1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued

coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(*l*) The Office shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1)[1] of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d)).

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[1] See References in Text note below.

(m) (1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

(2) (A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

(1) to implement hospitalization-cost-containment measures, such as measures—

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(*o*) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

5 U.S.C. § 8906. Contributions

(a) (1) Not later than October 1 of each year, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

(A) enrollments under this chapter for self alone;

(B) enrollments under this chapter for self plus one; and

(C) enrollments under this chapter for self and family.

(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be

commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

(3) For purposes of paragraph (2), the term "enrollee" means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

(b) (1) Except as provided in paragraphs (2), (3), and (4), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1)(A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.

(2) The biweekly Government contribution for an employee or annuitant enrolled in a plan under this chapter shall not exceed 75 percent of the subscription charge.

(3) In the case of an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title), the biweekly Government contribution shall be equal to the percentage which bears the same ratio to the percentage determined under this subsection (without regard to this paragraph) as the average number of hours of such employee's regularly scheduled workweek bears to the average

number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time career basis (as determined under regulations prescribed by the Office).

(4) In the case of persons who are enrolled in a health benefits plan as part of the demonstration project under section 1108 of title 10, the Government contribution shall be subject to the limitation set forth in subsection (i) of that section.

(c) There shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) the annuity of each enrolled annuitant and there shall be contributed by the Government, amounts, in the same ratio as the contributions of the employee or annuitant and the Government under subsection (b) of this section, which are necessary for the administrative costs and the reserves provided for by section 8909(b) of this title.

(d) The amount necessary to pay the total charge for enrollment, after the Government contribution is deducted, shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) from the annuity of each enrolled annuitant. The withholding for an annuitant shall be the same as that for an employee enrolled in the same health benefits plan and level of benefits.

(e) (1) (A) An employee enrolled in a health benefits plan under this chapter who is placed in a leave without pay status may have his coverage and the coverage of members of his family continued under the plan for not to exceed 1 year under regulations prescribed by the Office.

(B) During each pay period in which an enrollment continues under subparagraph (A)—

(i) employee and Government contributions required by this section shall be paid on a current basis; and

(ii) if necessary, the head of the employing agency shall approve advance payment, recoverable in the same manner as under section 5524a(c), of a portion of basic pay sufficient to pay current employee contributions.

(C) Each agency shall establish procedures for accepting direct payments of employee contributions for the purposes of this paragraph.

(2) An employee who enters on approved leave without pay to serve as a full-time officer or employee of an organization composed primarily of employees as defined by section 8901 of this title, within 60 days after entering on that leave without pay, may file with his employing agency an election to continue his health benefits enrollment and arrange to pay currently into the Employees Health Benefits Fund, through his employing agency, both employee and agency contributions from the beginning of leave without pay. The employing agency shall forward the enrollment charges so paid to the Fund. If the employee does not so elect, his enrollment will continue during nonpay status and end as provided by paragraph (1) of this subsection and implementing regulations.

(3) (A) An employing agency may pay both the employee and Government contributions, and any additional administrative expenses otherwise chargeable to the employee, with respect to health care coverage for an employee described in subparagraph (B) and the family of such employee.

(B) An employee referred to in subparagraph (A) is an employee who—

(i) is enrolled in a health benefits plan under this chapter;

(ii) is a member of a reserve component of the armed forces;

(iii) is called or ordered to active duty in support of a contingency operation (as defined in section 101(a)(13) of title 10);

(iv) is placed on leave without pay or separated from service to perform active duty; and

(v) serves on active duty for a period of more than 30 consecutive days.

(C) Notwithstanding the one-year limitation on coverage described in paragraph (1)(A), payment may be made under this paragraph for a period not to exceed 24 months.

(f) The Government contribution, and any additional payments under subsection (e)(3)(A), for health benefits for an employee shall be paid—

(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

(3) in the case of an employee of the legislative branch who is paid by the Chief Administrative Officer of the House of Representatives, from the applicable accounts of the House of Representatives; and

(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

(g) (1) Except as provided in paragraphs (2) and (3), the Government contributions authorized by this section for health benefits for an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

(2) (A) The Government contributions authorized by this section for health benefits for an individual who first becomes an annuitant by reason of retirement from employment with the United States Postal Service on or after July 1, 1971, or for a survivor of such an individual or of an individual who died on or after July 1, 1971, while employed by the United States Postal Service, shall through September 30, 2016, be paid by the United States Postal Service, and thereafter shall be paid first from the Postal Service Retiree Health Benefits Fund up to the amount contained in the Fund, with any remaining amount paid by the United States Postal Service.

(B) In determining any amount for which the Postal Service is liable under this paragraph, the amount of the liability shall be prorated to reflect only that portion of total service which is attributable to civilian service performed (by the former postal employee or by the deceased individual referred to in subparagraph (A), as the case may be) after June 30, 1971, as estimated by the Office of Personnel Management.

(3) The Government contribution for persons enrolled in a health benefits plan as part of the demonstration project under section 1108 of title 10 shall be paid as provided in subsection (i) of that section.

(h) The Office shall provide for conversion of biweekly rates of contribution specified by this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

(i) An annuitant whose annuity is insufficient to cover the withholdings required for enrollment in a particular health benefits plan may enroll (or remain enrolled) in such plan, notwithstanding any other provision of this section, if the annuitant elects, under conditions prescribed by regulations of the Office, to pay currently into the Employees Health Benefits Fund, through the retirement system that administers the annuitant's health benefits enrollment, an amount equal to the withholdings that would otherwise be required under this section.

5 U.S.C. § 8907. Information to individuals eligible to enroll

(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by sections 8903 and 8903a of this title.

(b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the—

(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

(2) procedure for obtaining benefits; and

(3) principal provisions of the plan affecting the enrollee and any eligible family members.

5 U.S.C. § 8909. Employees Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available—

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) A percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the Office to be reasonably adequate to provide a contingency reserve.

The Office, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other re-

funds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of enrollees and the Government to, or to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

(d) When the assets, liabilities, and membership of employee organizations sponsoring or underwriting plans approved under section 8903(3) or 8903a of this title are merged, the assets (including contingency reserves) and liabilities of the plans sponsored or underwritten by the merged organizations shall be transferred at the beginning of the contract term next following the date of the merger to the plan sponsored or underwritten by the successor organization. Each employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title affected by a merger shall be transferred to the plan sponsored or underwritten by the successor organization unless he enrolls in another plan under this chapter. If the successor organization is an organization described in section 8901(8)(B) of this title, any employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title so transferred may not remain enrolled in the plan after the end of the contract term in which the merger occurs unless that individual is a full member of such

organization (as determined under section 8903a(d) of this title).

(e) (1) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

(f) (1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan admin-

istration subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(g) The fund described in subsection (a) is available to pay costs that the Office incurs for activities associated with implementation of the demonstration project under section 1108 of title 10.

5 U.S.C. § 8913(a). Regulations (1970)

(a) The Civil Service Commission may prescribe regulations necessary to carry out this chapter.

* * *

5 U.S.C. § 8913. Regulations

(a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.

(b) The regulations of the Office may prescribe the time at which and the manner and conditions under which an employee is eligible to enroll in an approved health benefits plan described by section 8903 or 8903a of this title. The regulations may exclude an employee on the basis of the nature and type of his employment or conditions pertaining to it, such as short-term appointment, seasonal or intermittent employment, and employment of like nature. The Office may not exclude—

(1) an employee or group of employees solely on the basis of the hazardous nature of employment;

(2) a teacher in the employ of the Board of Education of the District of Columbia, whose pay is fixed by section 1501 of title 31, District of Columbia Code, on the basis of the fact that the teacher is serving under a temporary appointment if the teacher has been so employed by the Board for a period or periods totaling not less than two school years;

(3) an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title); or

(4) an employee who is employed on a temporary basis and is eligible under section 8906a(a).

(c) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefits plans. The regulations may permit the coverage to continue, exclusive of the temporary extension of coverage described by section 8902(g) of this title, until the end of the pay period in which an employee is separated from the service, or until the end of the month in which an annuitant or former spouse ceases to be entitled to annuity, and in case of the death of an employee or annuitant, may permit a temporary extension of the coverage of members of his family for not to exceed 90 days.

(d) The Secretary of Agriculture shall prescribe regulations to effect the application and operation of this chapter to an individual named by section 8901(1)(H) of this title.

5 U.S.C. § 8959. Preemption

The terms of any contract that relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to dental benefits, insurance, plans, or contracts.

5 U.S.C. § 8989. Preemption

The terms of any contract that relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to vision benefits, insurance, plans, or contracts.

5 U.S.C. § 9005. Preemption

(a) CONTRACTUAL PROVISIONS.—The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to long-term care insurance or contracts.

(b) PREMIUMS.—

(1) IN GENERAL.—No tax, fee, or other monetary payment may be imposed or collected, directly or indirectly, by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, on, or with respect to,

any premium paid for an insurance policy under this chapter.

(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to exempt any company or other entity issuing a policy of insurance under this chapter from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such entity from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

9 U.S.C. § 2. Validity, irrevocability, and enforcement of agreements to arbitrate

A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

10 U.S.C. § 1103. Contracts for medical and dental care: State and local preemption

(a) OCCURRENCE OF PREEMPTION.—A law or regulation of a State or local government relating to health insurance, prepaid health plans, or other health care delivery or financing methods shall not apply to any contract entered into pursuant to this chapter by the

Secretary of Defense or the administering Secretaries to the extent that the Secretary of Defense or the administering Secretaries determine that—

(1) the State or local law or regulation is inconsistent with a specific provision of the contract or a regulation promulgated by the Secretary of Defense or the administering Secretaries pursuant to this chapter; or

(2) the preemption of the State or local law or regulation is necessary to implement or administer the provisions of the contract or to achieve any other important Federal interest.

(b) EFFECT OF PREEMPTION.—In the case of the preemption under subsection (a) of a State or local law or regulation regarding financial solvency, the Secretary of Defense or the administering Secretaries shall require an independent audit of the prime contractor of each contract that is entered into pursuant to this chapter and covered by the preemption. The audit shall be performed by the Defense Contract Audit Agency.

(c) STATE DEFINED.—In this section, the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, and each possession of the United States.

12 U.S.C. § 1. Office of Comptroller of the Currency (1996)

There shall be in the Department of the Treasury a bureau charged with the execution of all laws passed by Congress relating to the issue and regulation of a national currency secured by United States bonds

and, under the general supervision of the Board of Governors of the Federal Reserve System, of all Federal Reserve notes, except for the cancellation and destruction, and accounting with respect to such cancellation and destruction, of Federal Reserve notes unfit for circulation, the chief officer of which bureau shall be called the Comptroller of the Currency, and shall perform his duties under the general directions of the Secretary of the Treasury. The Comptroller of the Currency shall have the same authority over matters within the jurisdiction of the Comptroller as the Director of the Office of Thrift Supervision has over matters within the Director's jurisdiction under section 1462a(b)(3) of this title. The Secretary of the Treasury may not delay or prevent the issuance of any rule or the promulgation of any regulation by the Comptroller of the Currency.

12 U.S.C. § 85. Rate of interest on loans, discounts and purchases

Any association may take, receive, reserve, and charge on any loan or discount made, or upon any notes, bills of exchange, or other evidences of debt, interest at the rate allowed by the laws of the State, Territory, or District where the bank is located, or at a rate of 1 per centum in excess of the discount rate on ninety-day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and no more, except that where by the laws of any State a different rate is limited for banks organized under State laws, the rate so limited shall be allowed for associations organized or existing in any such State under title 62 of the Revised Statutes. When no rate is

fixed by the laws of the State, or Territory, or District, the bank may take, receive, reserve, or charge a rate not exceeding 7 per centum, or 1 per centum in excess of the discount rate on ninety day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and such interest may be taken in advance, reckoning the days for which the note, bill, or other evidence of debt has to run. The maximum amount of interest or discount to be charged at a branch of an association located outside of the States of the United States and the District of Columbia shall be at the rate allowed by the laws of the country, territory, dependency, province, dominion, insular possession, or other political subdivision where the branch is located. And the purchase, discount, or sale of a bona fide bill of exchange, payable at another place than the place of such purchase, discount, or sale, at not more than the current rate of exchange for sight drafts in addition to the interest, shall not be considered as taking or receiving a greater rate of interest.

12 U.S.C. § 93a. Authority to prescribe rules and regulations (1996)

Except to the extent that authority to issue such rules and regulations has been expressly and exclusively granted to another regulatory agency, the Comptroller of the Currency is authorized to prescribe rules and regulations to carry out the responsibilities of the office, except that the authority conferred by this section does not apply to section 36 of this title or to securities activities of National Banks under the Act commonly known as the "Glass-Steagall Act".

21 U.S.C. § 360k. State and local requirements respecting devices

(a) General rule

Except as provided in subsection (b) of this section, no State or political subdivision of a State may establish or continue in effect with respect to a device intended for human use any requirement—

(1) which is different from, or in addition to, any requirement applicable under this chapter to the device, and

(2) which relates to the safety or effectiveness of the device or to any other matter included in a requirement applicable to the device under this chapter.

(b) Exempt requirements

Upon application of a State or a political subdivision thereof, the Secretary may, by regulation promulgated after notice and opportunity for an oral hearing, exempt from subsection (a) of this section, under such conditions as may be prescribed in such regulation, a requirement of such State or political subdivision applicable to a device intended for human use if—

(1) the requirement is more stringent than a requirement under this chapter which would be applicable to the device if an exemption were not in effect under this subsection; or

(2) the requirement—

(A) is required by compelling local conditions, and

(B) compliance with the requirement would not cause the device to be in violation of

any applicable requirement under this chapter.

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for pur-

poses of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 through 393–51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State

of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6) (A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements

which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(e) Automatic contribution arrangements

(1) Notwithstanding any other provision of this section, this subchapter shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement—

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 1104(c)(5) of this title.

(3) (A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which—

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

49 U.S.C. § 41713. Preemption of authority over prices, routes, and service

(a) DEFINITION.—In this section, "State" means a State, the District of Columbia, and a territory or possession of the United States.

(b) PREEMPTION.—(1) Except as provided in this subsection, a State, political subdivision of a State, or political authority of at least 2 States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.

(2) Paragraphs (1) and (4) of this subsection do not apply to air transportation provided entirely in Alaska unless the transportation is air transportation (except charter air transportation) provided under a certificate issued under section 41102 of this title.

(3) This subsection does not limit a State, political subdivision of a State, or political authority of at least 2 States that owns or operates an airport served by an air carrier holding a certificate issued by the Secretary of Transportation from carrying out its proprietary powers and rights.

(4) TRANSPORTATION BY AIR CARRIER OR CARRIER AFFILIATED WITH A DIRECT AIR CARRIER.—

(A) GENERAL RULE.—Except as provided in subparagraph (B), a State, political subdivision of a State, or political authority of 2 or more States may not enact or enforce a law,

regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier or carrier affiliated with a direct air carrier through common controlling ownership when such carrier is transporting property by aircraft or by motor vehicle (whether or not such property has had or will have a prior or subsequent air movement).

(B) MATTERS NOT COVERED.—Subparagraph (A)—

(i) shall not restrict the safety regulatory authority of a State with respect to motor vehicles, the authority of a State to impose highway route controls or limitations based on the size or weight of the motor vehicle or the hazardous nature of the cargo, or the authority of a State to regulate motor carriers with regard to minimum amounts of financial responsibility relating to insurance requirements and self-insurance authorization; and

(ii) does not apply to the transportation of household goods, as defined in section 13102 of this title.

(C) APPLICABILITY OF PARAGRAPH (1).—This paragraph shall not limit the applicability of paragraph (1).

49 U.S.C. app. § 1305. Federal preemption (1988)

(a) Preemption

(1) Except as provided in paragraph (2) of this subsection, no State or political subdivision thereof and no interstate agency or other political agency of two or more States shall enact or enforce any law, rule, regulation, standard, or other provision having the force and effect of law relating to rates, routes, or services of any air carrier having authority under subchapter IV of this chapter to provide air transportation.

(2) Except with respect to air transportation (other than charter air transportation) provided pursuant to a certificate issued by the Board under section 1371 of this Appendix, the provisions of paragraph (1) of this subsection shall not apply to any transportation by air of persons, property, or mail conducted wholly within the State of Alaska.

(b) Proprietary powers and rights

(1) Nothing in subsection (a) of this section shall be construed to limit the authority of any State or political subdivision thereof or any interstate agency or other political agency of two or more States as the owner or operator of an airport served by any air carrier certificated by the Board to exercise its proprietary powers and rights.

(2) Any aircraft operated between points in the same State (other than the State of Hawaii) which in the course of such operation crosses a boundary between two States, or between the United States and any other country, or between a State and the beginning of the territorial waters of the United States,

shall not, by reason of crossing such boundary, be considered to be operating in interstate or overseas air transportation.

(c) Existing State authority

When any intrastate air carrier which on August 1, 1977, was operating primarily in intrastate air transportation regulated by a State receives the authority to provide interstate air transportation, any authority received from such State shall be considered to be part of its authority to provide air transportation received from the Board under subchapter IV of this chapter, until modified, suspended, amended, or terminated as provided under such subchapter.

(d) "State" defined

For purposes of this section, the term "State" means any State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, Guam, the Virgin Islands, and any territory or possession of the United States.

5 C.F.R. § 890.101. Definitions; time computations *(excerpts)*

* * *

Reimbursement means a carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection withthat illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the

covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

* * *

Subrogation means a carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

* * *

5 C.F.R. § 890.106. Carrier entitlement to pursue subrogation and reimbursement recoveries

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section.

(b) (1) Any FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(2) Any health benefits plan contract that contains a subrogation or reimbursement clause shall

provide that benefits and benefit payments are extended to a covered individual on the condition that the FEHB carrier may pursue and receive subrogation and reimbursement recoveries pursuant to the contract.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of 5 CFR 890.101 and is therefore not subject to the disputed claims process set forth at 5 CFR 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 C.F.R. § 890.503. Reserves

(a) The enrollment charge consists of the rate approved by OPM for payment to the plan for each enrollee, plus 4 percent, of which one part is for an administrative reserve and 3 parts are for a contingency reserve for the plan.

(b) The administrative reserve is credited with the one one-hundred-and-fourth of the enrollment charge set aside for the administrative reserve. The administrative reserve is available for payment of administrative expenses of OPM incurred under this part, and for such other purposes as may be authorized by law.

(c) (1) *Contingency reserve.* The contingency reserve for each plan is credited with—

(i) The three one-hundred-and-fourths of the enrollment charge set aside for the contingency reserve from the enrollment charges for employees and annuitants enrolled for that plan;

(ii) Amounts transferred in accordance with law from other contingency reserves and the administrative reserve;

(iii) Income from investment of the reserve;

(iv) Its proportionate share of the income from investment of the administrative reserve; and

(v) Any return of reserves of the plan.

(2) *Contingency reserve minimum balance.* The preferred minimum balance for the contingency reserve for community-rated plans is 1 month's subscription charges at the average recurring monthly rate paid from the Employees Health Benefits Fund for the plan during the most recent contract period. The preferred minimum balance for the contingency reserve for experience-rated plans is 1½ times an amount equal to the sum of an average month's paid claims plus an

average month's administrative expenses and retentions, as determined under paragraph (c)(3) of this section. Amounts in excess of the preferred minimum balance for a contingency reserve account may be used with respect to the plan from which the reserve derives: To defray increases in future rates; to increase plan benefits, or to reduce contributions of eligible subscribers and the Government under the program through devices such as temporary suspension of, or reduction in, required contributions or a refund of contributions to eligible subscribers and the Government.

(3) *OPM/carrier reserve transfers.* The target level for total reserves of an experience-rated plan is 31/2 times an amount equal to the sum of an average month's paid claims plus an average month's administrative expenses and retentions. Reserves include funds set aside for incurred-but-unpaid benefit claims and the "special" reserve representing the cumulative difference between income to the plan (subscription income plus interest on investments) and plan expenses (benefit costs plus administrative expenses and retentions). Included as carrier reserves is the balance in the letter of credit (LOC) account maintained by OPM for the plan. For the purposes of this section, an average month's paid claims is one-sixth of the total claims paid during the last 6 months of the most recent contract period, and an average month's administrative expenses and retentions is one-twelfth of the administrative expenses and retentions for the most recent contract period.

(i) When, as of the end of a contract period, the total of all the reserves for an experience-

rated plan is less than the target level described in the first four sentences of paragraph (c)(3) of this section, the carrier is entitled to payment from the contingency reserve. Such contingency reserve payment shall equal the lesser of: An amount equal to the difference between the target level for the plan's reserves and the total of the reserves for the plan, or an amount equal to the excess, if any, of the contingency reserve over the preferred minimum balance. OMP must authorize this payment promptly after accepting the accounting statement for the contract period. The contingency reserve payment so authorized will be made available to the carrier's LOC account.

(ii) When, as of the end of a contract period, the total of all reserves of an experience-rated plan amounts to more than the plan's target level, the excess over the plan's target level must be credited to the contingency reserve maintained by OPM for the plan. OPM will withdraw the excess amount from the plan's LOC account, based on reporting in the annual accounting statement for the year, no sooner than May 1, of the following year. If the accounting statement is not filed by the time limit specified in the plan's contract with OPM, OPM will estimate the amount of the excess reserves and may withdraw that amount from the plan's LOC account, or begin the process of offsetting that amount from subscription payments, no sooner than May 1. The amount withdrawn from the plan's LOC account, or offset from subscription payments,

will be credited to that plan's contingency reserve.

(4) OPM may, by agreement with the carrier, approve community rating for a comprehensive plan. If the contingency reserve of the carrier of a community-rated plan exceeds the preferred minimum balance, as described in paragraph (c)(2) of this section, the carrier may request OPM to pay to the plan a portion of the reserve not greater than the excess of the contingency reserve over the preferred minimum balance. The carrier shall state the reason for the request. OPM will decide whether to allow the request in whole or in part and will advise the plan of its decision.

(5) *Special contingency reserve transfers.* In addition to those amounts, if any, paid under paragraphs (c)(2) through (c)(4) of this section, OPM may authorize such other payments from the contingency reserve as in the judgment of OPM may be in the best interest of employees and annuitants enrolled in the program. A carrier for a plan may apply to OPM at any time for a payment from the contingency reserve when the carrier has good cause, such as unexpected claims experience and variations from expected community rates. In the administration of this part, OPM will accord a high priority to deciding whether to allow requests under this paragraph in whole or in part and will promptly advise the carrier of its decision. Amounts paid from the contingency reserve under paragraphs (c)(2) through (5) of this section shall be reported as subscription income in the year in which paid. By agreement with the carrier and where good cause exists, OPM may accept payment from carrier reserves for credit to the

contingency reserve in an amount and under conditions other than those specified in paragraph (c) of this section. For carriers funded by LOC, the returned amount will be withdrawn from the plan's LOC account.

(6) *Subsidization penalty reserve.* This reserve account shall be credited with all subsidization penalties levied against community rated plans outlined in 48 CFR 1615.402(c)(3)(ii)(B). The funds in this account shall be annually distributed to the contingency reserves of all community rated plans subject to the FEHB-specific medical loss ratio threshold on a pro-rata basis. The funds will not be used for one specific carrier or plan.

48 C.F.R. § 1602.170-2. Community rate

(a) *Community rate* means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan carrier. References in this subchapter to "a combination of cost and price analysis" relating to the applicability of policy and contract clauses refer to comprehensive medical plan carriers using community rates.

(b) *Adjusted community rate* means a community rate which has been adjusted for expected use of medical resources of the FEHBP group. An adjusted community rate is a prospective rate and cannot be retroactively revised to reflect actual experience, utilization, or costs of the FEHBP group, except as described in § 1615.402(c)(4).

48 C.F.R. § 1602.170-7. Experience-rate

Experience-rate means a rate for a given group that is the result of that group's actual paid claims, administrative expenses (including capitated administrative expenses), retentions, and estimated claims incurred but not reported, adjusted for benefit modifications, utilization trends, and economic trends. Actual paid claims include any actual or negotiated benefits payments made to providers of services for the provision of healthcare such as capitation not adjusted for specific groups, including mental health benefits capitation rates, per diems, and DRG payments.

48 C.F.R. § 1632.170. Recurring premium payments to carriers

(a) (1) *Recurring payments to carriers of community-rated plans.* OPM will pay to carriers of community-rated plans the premium payments received for the plan less the amounts credited to the contingency and administrative reserves, amounts assessed under paragraph (a)(2) of this section, and amounts due for other contractual obligations. Premium payments will be due and payable not later than 30 days after receipt by the Federal Employees Health Benefits (FEHB) Fund.

(2) The difference between one percent and the performance based percentage of the contract price described at 1615.404–4 will be multiplied by the carrier's subscription income for the year of performance and the resulting amount (performance adjustment) will be withheld from the net-to-carrier premium disbursement during the first

quarter of the following contract period unless an alternative payment arrangement is made with the carrier's Contracting Officer. Amounts withheld from a community rated plan's premium disbursement will be deposited into the plan's Contingency Reserve.

(3) Any subsidization penalty levied against a community rated plan as outlined in 48 CFR 1615.402(c)(3)(ii)(B) must be paid within 60 days from notification. If payment is not received within the 60 day period, OPM will withhold from the community rated carriers the periodic premium payment payable until fully recovered. OPM will deposit the withheld funds in the subsidization penalty reserve described in 5 CFR 890.503(c)(6).

(b) (1) *Recurring payments to carriers of experience-rated plans.* OPM will make payments on a letter of credit (LOC) basis. Premium payments received for the plan, less the amounts credited to the contingency and administrative reserves and amounts for other obligations due under the contract, will be made available for carrier drawdown not later than 30 days after receipt by the FEHB Fund.

(2) Withdrawals from the LOC account will be made on a checks-presented basis. Under a checks-presented basis, drawdown on the LOC is delayed until the checks issued for FEHB Program disbursements are presented to the carrier's bank for payment.

(3) OPM may grant a waiver of the restriction of LOC disbursements to a checks-presented basis if the carrier requests the waiver in writing and

demonstrates to OPM's satisfaction that the checks-presented basis of LOC disbursements will result in significantly increased liability under the contract, or that the checks-presented basis of LOC disbursements is otherwise clearly and significantly detrimental to the operation of the plan. Payments to carriers that have been granted a waiver may be made by an alternative payment methodology, subject to OPM approval.

FOR ENROLLMENT

RECORD AND BRIEFS

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IN THE

Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,
Petitioner,

v.

JODIE NEVILS,
Respondent.

On Writ of Certiorari to the Supreme Court of Missouri

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QUESTIONS PRESENTED

1. Whether FEHBA preempts state laws that prevent carriers from seeking subrogation or reimbursement pursuant to their FEHBA contracts.

2. Whether FEHBA's express-preemption provision, 5 U.S.C. § 8902(m)(1), violates the Supremacy Clause.

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INTRODUCTION

The Supremacy Clause provides that only the "Constitution," "Treaties," and "Laws of the United States" may preempt state law. U.S. Const. Art. VI, cl. 2. Yet, as this Court has recognized, the Federal Employee Health Benefits Act's express preemption clause "declares no federal law preemptive" and instead purportedly "renders preemptive contract terms in health insurance plans." *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 697-98 (2006). "A prescription of that unusual order," *id.*, cannot, consistent with the Supremacy Clause, trump the law of a sovereign state.

Coventry and the government contend that Congress is free to turn the power to preempt state law over to the terms of contracts so long as some statute "declares" those unseen terms supreme. Pet. Br. 57; U.S. Br. 30. But the Constitution does not allow preemption to be outsourced to contracts, even contracts with a government agency. Contracts are not "laws."

Federal laws (including properly promulgated regulations) may override the States' concurrent exercise of sovereignty because they come with the guarantee of a relatively formal procedure that fosters the fairness and deliberation that should underlie a pronouncement of such force. This process preserves accountability for actions that intrude on state law, and it affords protection to citizens who may hold rights under those laws.

There is no precedent for the rule Coventry urges. Although the U.S. Code is peppered with preemption provisions, FEHBA's is unprecedented. Under Coventry's theory, even a contract between two *private parties* can force state law to yield. Pet. Br. 57-58; U.S. Br. 29-30. As the Chief Justice observed when the Court first confronted this "puzzling" clause a decade ago, a statutory provision that purports to give preemptive force to

the terms of a privately negotiated contract could allow a reimbursement clause requiring repayment at 20% interest to displace any contrary state usury law. And Coventry's novel theory goes beyond the outsourcing of preemption to contracts. If it is right, Congress could simply "declare" that private guidelines to be set in the future by the meat industry, or by an animal-rights group, "shall supersede and preempt" any state law relating to animal welfare.

Although Coventry's attempt to expand this Court's preemption jurisprudence begins at the Supremacy Clause, it does not end there. Joined by the government, Coventry has also proposed an unprecedented expansion of *Chevron* deference that would hand federal agencies the "authoritative" power to displace state law by bureaucratic fiat, on the basis of no more than a generic grant of authority to "administer" a statute. Pet. Br. 52; U.S. Br. 22. But administrative agencies aren't designed to represent the interests of states, and they lack any special authority to referee the delicate balance of state and federal power. Because agencies are creatures of Congress, they must have express authorization from Congress before they can "pre-empt state law directly." *Wyeth v. Levine*, 555 U.S. 555, 576 (2009). FEHBA confers no such authorization.

A ruling endorsing the Office of Personnel Management's preemption regulation would mark a definitive victory in the agency's decade-long crusade against state laws restricting subrogation and reimbursement. But at what cost to principles of federalism? The agency could have asked Congress to amend FEHBA (as it has done many times before) to address any perceived problem with these state laws. It did not do so. It could argue to a court that these state rules stand as an obstacle to the purposes and objectives of the FEHBA program. It did not do that either. Instead, the agency sought a bigger

prize: the power for it (instead of Congress) to decide which state laws survive and which do not. OPM's zeal to short-circuit the legislative and judicial process should not be embraced.

Despite the serious constitutional problems presented here, the Court may resolve this case modestly. In *McVeigh*, this Court found that FEHBA's text is open to two "plausible constructions"—one in which contractual subrogation clauses fall within the statute's compass, and one in which they do not. 547 U.S. at 697-98. The Court also warned that FEHBA's preemption clause "warrants cautious interpretation," and instructed that "a modest reading of the provision is in order." *Id.* Following that lesson here—by adopting an interpretation of FEHBA that does not allow contract terms to preempt state law—would avoid the serious Supremacy Clause issues presented while preserving the States' traditional oversight of insurance regulation.

STATEMENT

I. FEHBA's regulatory background

A. Congress establishes a federal health-benefits program designed to leverage the expertise of the private insurance marketplace.

In 1959, Congress enacted FEHBA, 5 U.S.C. § 8901 *et seq.*, to close the "wide gap" in access to comprehensive health care between federal workers and private employees by giving federal employees "substantially equal" options. H.R. Rep. No. 86-957, at 2914 (1959) (JA 268-69). But while the 1950s saw "spectacular increases" in private "major medical insurance" plans, the federal government lacked "previous experience" in the area. *Id.* at 2915 (JA 270). Congress therefore opted for a decentralized approach that took advantage of the already thriving private-insurance marketplace.

The result, as anyone who has worked for the federal government knows, is that there is no single federal health-insurance provider and no uniform benefits plan. Instead, under FEHBA, employees get a "free choice" from among plans offered by the same insurers that service "private employers" nationwide. *Id.* at 2914-15 (JA 268-70); *see* § 8902(a).

B. Congress taps OPM to negotiate contracts on behalf of the government with private insurers.

The U.S. Civil Service Commission (now known as OPM) was charged with administering the program and negotiating health-insurance contracts. *Id.* at 2916 (JA 272); *see* § 8902; 5 C.F.R. § 890.201-05; 48 C.F.R. § 1602.170-11. Congress established a no-bid contracting process, allowing private insurers to offer existing plans to federal employees. *See* § 8902(a). To be eligible, an insurer must be licensed to provide health insurance under state law, *see* § 8902(b), and provide either an "experience-rated" plan (known as a fee-for-service plan) or a "community-rated" plan (essentially a local health maintenance organization, or HMO). 48 C.F.R. §§ 1602.170-2, 1602.170-7; *see generally* Annie L. Mach & Ada S. Cornell, Cong. Research Serv., *Federal Employees Health Benefits Program (FEHBP): Available Health Insurance Options* 1 (2013) (CRS Report).

The decision to "approve" and offer plans falls entirely within OPM's discretion, and neither the statute nor any regulations allow for judicial review of, or public participation in, the contracting process. *See* 5 C.F.R. § 890.203 (authorizing approval of plans based on the "judgment of OPM").

C. The agency's contracting process generates hundreds of plans offering a wide range of benefit and coverage options.

OPM's annual contracting program has given rise to hundreds of different plan options for federal employees (approximately 256 in 2014). *See* CRS Report at 3. Because OPM enters into contracts with local carriers providing services in specific communities, many of the options are tied to a particular region, meaning that most workers have "10 to 15 different plans" from which to choose, "depending on where the individual resides." *Id.* at 3, 6. In Missouri, federal employees choose from 23 different basic plans—ranging from a fee-for-service Blue Cross plan to a local "Kansas City Metro Area" HMO. Office of Personnel Management, 2015 Plan Information for Missouri, http://bit.ly/2h1jkm3.

Although not every plan or option is available to every federal worker, the program's decentralized, regional nature has created wide variety among the benefits available. Some plans cover just individuals while others cover families. Some plans offer low premiums and a high deductible while others offer the reverse. One policy might cover 10 visits to a certified acupuncturist while another could cover 25. And some plans pay for fertility drugs while others categorically do not. *See id.* FEHBA promotes this variation: Although a benefit plan must "contain a detailed statement of benefits offered," the statute imposes no specific requirements governing its content. *See* § 8902(d).

Premiums are also sensitive to region-specific characteristics. Because premium rates vary widely among states, *see* Henry J. Kaiser Family Found., *Average Per Person Monthly Premiums in the Individual Market, 2013*, http://kaiserf.am/2i1ck02, Congress directed community-rated plans (like Coventry's) to calculate premi-

ums in accordance with the rates of similar plans offered to local private employers, which are bound by applicable state and local laws. H.R. Rep. No. 86-957 at 2923 (JA 286).

When calculating rates, Congress also forbade community-rated plans from taking subrogation and reimbursement directly into account. A community-rated plan like Coventry's cannot carry forward any past "gains and losses . . . in the next year's premium." CRS Report at 4; *see also* 48 C.F.R. § 1602.170-2. It also may not credit any subrogation or reimbursement recoveries back to the government. *See* 48 C.F.R. § 1631.200 (explaining that these "cost principles" apply only to experience-rated plans); 48 C.F.R. §§ 31.201-5, 1631.201-70(a), (g), 1652.216-71(b)(2).

D. Both Congress and OPM repeatedly stress the importance of state regulatory oversight to the FEHBA program.

Because the participation of state-approved private insurers is a key feature of FEHBA, Congress intended the program to work alongside—not against—state law. Acknowledging that "[a]ll states regulate the health insurance business in various and varying ways," S. Rep. No. 95-903, at 7 (1978) (JA 359), Congress did "not design[]" the federal program "to regulate the insurance business or override any State regulatory scheme." Comptroller General of the United States, Gen. Accounting Office, *Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers* 15 (1975) (Comptroller Report) (JA 565).

The agency's "position on this matter" is longstanding: It has maintained that "the States have the authority to regulate and tax FEHB carriers." *Id.* at 6 (JA 556). And—at the specific request of Congress—it relayed this

understanding to insurers participating in the program, telling them "that the fact that they are administering a Federal contract is no reason for circumventing compliance with applicable State laws." *Id.* at 16 (JA 566).

FEHBA's dual state-federal regulatory approach has generally worked well. "During the early years," carriers had "few if any problems" complying with both federal and state requirements. S. Rep. No. 95-903, at 7 (JA 359). In the mid-1970s, however, some states began mandating health-insurance coverage for certain "kinds of benefits and medical practitioners"—"chiropractic[] services" or acupuncture, for instance—that were not typically covered by FEHB carriers. *See id.* at 2-4 (JA 353-54). These laws "presented serious problems" for FEHB carriers because they "placed carriers in serious jeopardy of loss of their license in a state unless they were to approve a payment" for a specific type of coverage "not provided under [a FEHB] contract but required by state law." *See id.* at 7 (JA 360); *see also* Comptroller Report at 9-11 (JA 557-61) (discussing representative "examples," including Nevada's law requiring coverage for "traditional oriental medicine, including acupuncture"; Maryland's law requiring payment for "psychologists, regardless of whether they are clinical psychologists"; and Massachusetts' law requiring payment for "inpatient confinement in a mental hospital for at least 60 days").[1]

To address this tension, carriers urged CSC to "issue a regulation restricting the applicability of State law

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[1] By the mid-1970s, many states had also placed restrictions on health-insurance subrogation and reimbursement recoveries. *See infra*, at 12. Yet, in neither its report to Congress nor its testimony in support of the bill did CSC or its carriers ever suggest that any of these laws presented serious problems.

to FEHB contracts." Comptroller Report at 15 (JA 565). The agency refused. *First*, it reiterated that its "position has been that 'the States have the authority to both regulate and tax health insurance carriers operating under [FEHBA].'" *Id.* It therefore told carriers that (1) "the FEHB Act was not designed to regulate the insurance business or to override any State regulatory scheme," and (2) "no legal basis exists for CSC to issue a regulation restricting the applicability of State laws to FEHB contracts." *Id. Second*, the agency's lawyers also informed the carriers that they did "not agree[]" that "the FEHB Act is exempt from State regulation." *Id.*

E. At the agency's request, Congress adds a "limited" preemption clause targeting uniform coverage and benefits.

Although the agency told its carriers that it lacked authority to override state law, it agreed to raise the concern with Congress. S. Rep. No. 95-903, at 3-4 (JA 367). CSC's Comptroller General urged Congress to adopt an express preemption provision for FEHBA that could "provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in [FEHB plans]." *Id.* at 4 (JA 369).

In 1978, Congress responded by adding the following preemption provision to FEHBA:

> The provisions of any contract under [FEHBA] which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1), Pub. L. No. 95-368 (1978).

Both Congress and the agency saw this amendment as "a form of limited preemption." H.R. Rep. No. 95-282, at 6 (1977) (JA 359); *see also* S. Rep. No. 95-903, at 4 (JA 369) (describing the provision as "purposely limited"). It was intended to authorize the FEHB contracts to "preempt the application" of a subset of state laws "which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage." H.R. Rep. No. 95-282, at 5 (JA 356); *see also* S. Rep. No. 95-903, at 4 (JA 369) (explaining that the clause "guarantees that the provisions of health benefit contracts . . . concerning benefits or coverage[] would preempt any state and/or local insurance laws and regulations which are inconsistent with such contracts").

To underscore the provision's narrowness, Congress explained that it was "not provid[ing] insurance carriers under the program with exemptions from state laws and regulations governing other aspects of the insurance business." S. Rep. No. 95-903, at 4 (JA 369). CSC was equally clear on this point, emphasizing that FEHBA's preemption clause had "limited applicability" and "would not . . . exempt" those carriers from laws and regulations "pertaining to the regulation of insurance within the State." H.R. Rep. No. 95-282, at 6 (JA 359). Instead, both Congress and the agency stressed that § 8902(m)(1) was intended to address "the problem of maintaining uniformity *of benefits* to all enrollees in the plan." *Id.* at 7 (JA 362) (emphasis added); *see also* S. Rep. No. 95-903, at 6 (JA 374) (reporting to Congress that the clause's aim was to "ensure that benefits and coverage under the program will be uniform").

F. After a second request, Congress amends FEHBA's preemption clause to allow carriers the flexibility to create provider networks.

Twenty years later, Congress amended the provision once again. *See* Pub. L. No. 105-266 (1998). Although the earlier version "prohibit[ed] state and local governments from regulating the nature and extent of coverage and benefits," some newer state laws had begun to interfere with the way "national plans" structured their services. H.R. Rep. No. 105-374, at 19 (1997) (JA 423). As an example, Congress pointed to "State-mandated 'any willing provider' statutes," which "jeopardized" some carriers' "effort[s] to establish a preferred provider organization (PPO) across the country." *Id.* at 9 (JA 403).[2]

To address this specific difficulty, Congress added "new language," that was intended to "preclude" states "from regulating the *provision* of coverage or benefits." S. Rep. No. 105-257, at 15 (1998) (JA 468) (emphasis added). Doing this "broaden[ed]" the clause "to enable national plans to offer uniform benefits and rates to enrollees regardless of where they live." *Id.* at 9 (JA 456); *see also* H.R. Rep. No. 105-374, at 9 (JA 403). But, as before, Congress stressed that "the only effect" of the newly amended clause "would be to limit the application of state law *in some circumstances*"—touching only those "states that have requirements governing what types of organization can provide health care when those requirements are different from those under federal contracts." S. Rep. No. 105-257, at 14 (JA 468-69) (emphasis

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[2] As before, neither OPM nor its carriers identified state insurance-subrogation restrictions as posing a problem. By the time of the 1998 amendments, however, nearly *every* state had adopted some form of state-law restriction on health-insurer-driven subrogation and reimbursement recoveries. *See infra*, at 12.

added); *see also id.* at 12 (JA 461) (noting that, "because the preemption would simply limit the application of state law in some circumstances, . . . the cost to state and local governments . . . would be minimal").

In its current form, the clause now states:

> The terms of any contract under [FEHBA] which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

II. This litigation

In 2006, respondent Jodie Nevils, a longtime postal worker, was injured in an automobile accident. Pet. App. 33a. As a federal employee, he received his health insurance through an OPM-approved plan offered by a local HMO based in Earth City, Missouri and run by petitioner Group Health Plan, now known as Coventry. *Id.* at 33a; JA 79. After Nevils recovered from his injuries, he initiated a tort action against the negligent driver who caused the accident. The parties reached a settlement. Pet. App. 16a. Coventry (through its agent) then asserted a lien on the settlement funds for the medical bills it paid ($6,592.24), and Nevils paid that amount to Coventry. *Id.* Later, Nevils filed suit in Missouri state court challenging Coventry's reimbursement demand. *Id.*

A. Coventry claims that its contract preempts Missouri's insurance-subrogation law.

At the time of Nevils's injuries, Coventry's OPM-approved contract directed it to "seek reimbursement or subrogation when an insured obtains a settlement judgment against a tortfeasor for payment of medical expenses." Pet. App. 45a. Coventry thus argued that, under

FEHBA, its contract superseded Missouri's law barring subrogation and reimbursement. *Id.* at 29a-32a.

Missouri, like nearly every state in the country, has long placed restrictions on health insurers that seek subrogation or reimbursement. *See id.* at 46a; *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 424 (Mo. Ct. App. 1965).[3] These various restrictions rest principally on the desire to protect the interests of insureds and their families against those of insurance companies. *See* E. Farish Percy, *Applying the Common Fund Doctrine to an ERISA-Governed Employee Benefit Plan's Claim for Subrogation or Reimbursement*, 61 Fla. L. Rev. 55, 57, 65-66 (2009) (explaining that most states have adopted rules to limit subrogation and reimbursement). As one court put it, "[i]t is manifestly unjust to require the recipient of medical payments, who pays a premium for such coverage," to then "act as a collection agency for the paying carrier in a suit against the tortfeasor." *Faust v. Luke*, 364 N.Y.S.2d 344, 347 (N.Y. Civ. Ct. 1975). These laws are also rooted in core tort law principles. *See*

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[3] *See generally* AFHO State Survey of Reimbursement Laws in the Health Insurance Context (Feb. 2014), http://bit.ly/2jpklAr. In many of these states, as in Missouri, laws restricting subrogation and reimbursement have been on the books since well before Congress amended FEHBA to add § 8902(m)(1). *See, e.g.*, Okla. Stat. Ann. tit. 36, § 6092 (1971) ("Limitations on subrogation and setoff under medical coverage"); Kan. Admin. Regs. § 40-1-20 (1966); *State Farm Fire & Cas. Co. v. Knapp*, 484 P.2d 180 (Ariz. 1971); *Berlinski v. Ovellette*, 325 A.2d 239 (Conn. 1973); *Fifield Manor v. Finston*, 354 P.2d 1073 (Cal. 1960); *State Farm Fire & Cas. Ins. Co. v. Farmers Ins. Exch.*, 489 P.2d 480 (Okl. 1971); *Wrightsman v. Hardware Dealers Mut. Fire Ins. Co.*, 147 S.E.2d 860 (Ga. 1966); *see generally* Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 735-37 (2005).

Great Am. Ins. Co. v. United States, 575 F.2d 1031, 1034 (2d Cir. 1978) (describing subrogation as "an exclusively derivative remedy which depends upon the claim of the insured and is subject to whatever defenses the tortfeasor has against the insured").

B. The Missouri Supreme Court's first decision.

The Missouri Supreme Court rejected Coventry's broad reading and held that FEHBA does not preempt Missouri's longstanding restrictions on subrogation and reimbursement. Its reasoning started with this Court's decision in *McVeigh*, which recognized that FEHBA "is subject to plausible, alternate interpretations" on the question whether it preempts state laws limiting reimbursement or subrogation. Pet. App. 49a (citing *McVeigh*, 546 U.S. at 697). Given this ambiguity, the Missouri court applied the presumption against preemption, and declined to displace Missouri's historic power over insurance and tort law. *Id.* at 51a-54a.

The court further held that its narrow reading comported with well-established practice in insurance law. *Id.* at 53a. The "subrogation provision in favor of [Coventry] creates a contingent right to reimbursement and bears no immediate relationship to the nature, provision or extent of Nevils' insurance coverage and benefits," as required for FEHBA preemption. *Id.* Indeed, the court noted, "Nevils would have been entitled to the same benefits had he never filed suit to recover damages for his injuries." *Id.* So subrogation and repayment may affect the parties' "net financial position *after* the provision of benefits," but it does not "affect the scope of coverage or the receipt of benefits." *Id.* (emphasis added).

Judge Wilson concurred in the judgment, concluding that "the preemption language in § 8902(m)(1) is not a valid application of the Supremacy Clause" and, "as a result, it has no effect." *Id.* at 56a. Reading the statute's

plain language, he reasoned that Congress "plainly intended" to give the terms in Coventry's *contract* preemptive effect. *Id.* at 65a. But "[t]he idea that . . . contract terms that Congress decrees—sight unseen—shall 'preempt and supersede' state law is such an unprecedented and unjustified intrusion on state sovereignty that it almost defies analysis." *Id.* at 66a.

C. OPM attempts to override those courts that refused to allow FEHBA to preempt state laws restricting subrogation.

Coventry petitioned for certiorari. While its petition was pending, OPM jumped into the fray. Purporting to exercise its power under FEHBA's generic grant of authority to "prescribe regulations necessary to carry out this chapter," 5 U.S.C. § 8913(a), OPM issued a regulation directly targeting the preemption issue in this case, *see* 5 C.F.R. § 890.106. That move reversed thirty years of settled practice. From at least 1975 to 2015, the agency had consistently taken the position that it had "no legal basis" under FEHBA "to issue a regulation restricting the applicability of State laws to FEHB contracts." Comptroller Report at 15 (JA 565). Indeed, even after *McVeigh* rejected OPM's plain-language argument, the agency continued to acknowledge its lack of authority to issue a regulation targeting state law, opting instead to produce an informal 2-page "carrier letter" reasserting that § 8902(m)(1) "preempts state laws prohibiting or limiting subrogation and reimbursement." FEHB Program Carrier Letter, at 1 (2012) (Pet. App. 116a).

In lower courts, OPM coupled this letter with a recycled version of its losing *McVeigh* merits brief and argued (once again) that FEHBA unambiguously preempts state subrogation laws. But after *McVeigh*, courts—including the Missouri Supreme Court—refused to permit the agency to alter the scope of preemption.

See Nevils v. Group Health Plan, Inc., 418 S.W.3d 451, 464-65 (Mo. 2014); *Kobold v. Aetna Life Ins. Co.*, 309 P.3d 924, 928-29 (Ariz. App. 2013).

In explicit response to these "state courts," the agency promulgated a rule expansively interpreting FEHBA to authorize contract terms to displace state insurance-subrogation laws. *See* OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29203 (May 21, 2015); 5 C.F.R. § 890.106(h). Although the regulation requires that every FEHB carrier include a "provision incorporating the carrier's subrogation and reimbursement rights," it specified no particular language or clause that these contracts must include, leaving the content of the contracts to future negotiations. *See id.*

The new regulation (which applies "in any pending or future case," 80 Fed. Reg. at 29204) provides:

> A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 C.F.R. § 890.106(h).

OPM made no effort to reconcile the new rule with its earlier position that "no legal basis exists" for the agency to issue "regulation[s] restricting the applicability of State laws to FEHB contracts." Comptroller Report at 15 (JA 565). Instead, the agency finally conceded that § 8902(m)(1)'s text was ambiguous, and argued, in turn, that the regulation's expansive preemption construction was entitled to *Chevron* deference. *See* U.S.

Amicus Br. 12, *Coventry Health Care of Mo., Inc. v. Nevils*, No. 13-1305 (U.S. May 22, 2015). In the wake of this intervening rule, the Solicitor General recommended that this Court remand the case to the Missouri Supreme Court. The Court agreed, remanding "for further consideration in light of new regulations promulgated by [OPM]." *Id.* at 73a.

D. The Missouri Supreme Court's second decision.

On remand, the Missouri Supreme Court rejected OPM's request for *Chevron* deference as inconsistent with this Court's cases, and adhered to its previous opinion. *Id.* at 5a. The court acknowledged the distinction between an agency interpretation of "'the substantive (as opposed to pre-emptive) *meaning* of a statute'" and "'the question of *whether* a statue is pre-emptive.'" *Id.* at 9a (quoting *Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735, 744 (1996)). It observed that "*Chevron* has been applied repeatedly to determine the substantive meaning of a statute," based on general grants of agency authority to administer a statutory scheme (as here). *Id.* at 5a. But, the court observed, "there is no indication that Congress delegated to the OPM the authority to make binding interpretations of the scope of the FEHBA preemption clause," and hence refused to extend *Chevron* deference. *Id.* at 3a, 5a.

Rather, the court explained, the "OPM rule does not alter the fact that the FEHBA preemption clause does not express Congress's clear and manifest intent to preempt Missouri's anti-subrogation law." *Id.* at 13a. And in light of FEHBA's conceded ambiguity, the court again concluded that the presumption against preemption and *McVeigh*'s mandate for a "cautious interpretation" required upholding state law. *Id.* at 7a (citing 547 U.S. at 697).

Judge Wilson, now joined by five other judges (a majority), again concurred on the grounds that FEHBA's "attempt to give preemptive effect to provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause." *Id.* at 14a.

SUMMARY OF THE ARGUMENT

FEHBA's express preemption clause cannot properly authorize Coventry's contract terms to displace Missouri's law prohibiting subrogation and reimbursement. Coventry's argument to the contrary rests on a series of unprecedented steps. *First*, that the Supremacy Clause permits Congress to expressly delegate preemptive power to terms in privately negotiated contracts. *Second*, that FEHBA's textual ambiguity must be resolved in favor of preemption—even in the state-dominated arena of insurance law. And *third*, that, even in the absence of any congressional delegation to the agency to expressly preempt state law, OPM's expansive interpretation of FEHBA to do just that deserves *Chevron* deference. Coventry's arguments in support of each of these novel conclusions are unpersuasive, and adopting any of them would have grave implications for the "oldest question of constitutional law": "the proper division of authority between the Federal Government and the States." *New York v. United States*, 505 U.S. 144, 149 (1992).

I. Congress cannot delegate preemptive power to contract terms. The Supremacy Clause instructs that it is the "*Laws* of the United States" that may reign supreme over state law. But "Laws" are official government-imposed policies, not negotiated contracts. Congress—acting within its enumerated powers and through bicameralism, presentment, and other measures ensuring deliberation and democratic participation—may enact statutes that intrude upon state law. And federal

agencies too, through formal rulemaking procedures, can promulgate regulations that carry the force and effect of law. A voluntary, bilateral contract, by contrast, is not a federal "Law" that can force the law of sovereign States to yield. Therefore, even if Congress purports to render yet-unseen contracts preemptive of state law, the Supremacy Clause precludes those contracts from assuming preemptive power. Rewriting FEHBA to say that it is *federal law* that does the preempting, as Coventry suggests, would completely change the statute's meaning. FEHBA unambiguously states that the "terms of any contract . . . shall supersede and preempt" state law.

II. The Court, consistent with its warning that § 8902(m)(1)'s "unusual" prescription "warrants [a] cautious interpretation," can avoid these serious constitutional problems. *McVeigh*, 547 U.S. at 697. FEHBA purports to give preemptive effect only to contract terms that relate to the "nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." In *McVeigh*, this Court recognized that this text is ambiguous on whether contractual subrogation and reimbursement terms "fall[] within § 8902(m)(1)'s compass" because they involve contingent post-benefit payments that stem from "state-court-initiated tort litigation" and do not affect what health-care services a plan participant receives. *Id.* at 697-98. Construing § 8902(m)(1) to leave state laws restricting subrogation and reimbursement in force avoids difficult constitutional problems while vindicating federalism concerns.

III. FEHBA's ambiguity does not justify *Chevron* deference to OPM's quest to expand the scope of FEHBA preemption. The Constitution places the power to preempt state law squarely in the hands of Congress—not unelected bureaucrats. *Chevron* holds that administrative agencies—due to their technical expertise and accountability through the Executive—are entitled

to deference on *policy* questions. But administrative agencies are "clearly not designed to represent the interests of States," and lack any special authority on important issues of state autonomy and federalism. *Watters v. Wachovia Bank, N.A.*, 550 U.S. 1, 41 (2007) (Stevens, J., dissenting). As a result, this Court has never extended *Chevron* deference to agency interpretations concerning the preemptive reach of statutes—at least not without Congress having clearly delegated that authority. It should not start now. Congress knows how to speak clearly when it decides to empower agencies to make express preemption decisions, and it has done so many times before, including in a parallel federal insurance scheme. Here, Congress has said no such thing.

ARGUMENT

I. The Supremacy Clause does not permit Coventry's contract terms to preempt state law.

A. The terms of contracts cannot reign "supreme" over state law.

1. The Constitution provides that the "*Laws* of the United States" are "the supreme Law of the Land" that are able to preempt state law. U.S. Const. art. VI, cl. 2 (emphasis added). But FEHBA's express preemption clause does something highly "unusual": It purportedly "renders preemptive contract terms in health insurance plans, not provisions enacted by Congress." *McVeigh*, 547 U.S. at 697; *see also id.* at 698 (explaining that the statute "declares no federal law preemptive, but instead, terms of an OPM[-]negotiated contract"). That prescription cannot force state law to give way. The terms of FEHB contracts, which are voluntarily negotiated between private insurance companies and unelected bureaucrats, are not "Laws" capable of displacing the democratic decisions of the sovereign States.

The Constitution gives preemptive force only to "explicit or implicit rules that bind the future exercise of governmental authority." Thomas W. Merrill, *Preemption and Institutional Choice*, 102 Nw. U. L. Rev. 727, 763 (2008). Thus, federal laws (including valid agency regulations) may preempt contrary state law because, unlike "contractual commitments voluntarily undertaken," they "prescrib[e] binding standards of conduct." *Am. Trucking Ass'ns, Inc. v. Los Angeles*, 133 S. Ct. 2096, 2102 (2013). But there is "no constitutional basis for making the terms of contracts with private parties . . . 'supreme' over state law," *Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 156 (2d Cir. 2005), and no authority for "the proposition that a contract to which the Federal government is a party somehow constitutes Federal law for the purposes of the supremacy clause," *Arthur D. Little, Inc. v. Comm'r of Health and Hosps.*, 481 N.E.2d 441, 452 (Mass. 1985). Indeed, this Court has *never* "devised and applied a federal principle of law" that terms in "individually negotiated contract[s]" can supersede state law. *United States v. Yazell*, 382 U.S. 341, 353 (1966).

Federalism demands strict adherence to the Constitution's limitations. The Framers "established a careful set of procedures that must be followed before federal law can be created under the Constitution." *Medellin v. Texas*, 552 U.S. 491, 515 (2008). That process, which includes "many accountability checkpoints"—including bicameralism and presentment—is "difficult by design." *Dep't of Transp. v. Ass'n of Am. R.R.s*, 135 S. Ct. 1225, 1237 (2015) (Alito, J., concurring) (quoting John F. Manning, *Lawmaking Made Easy*, 10 Green Bag 2d 191, 202 (2007)).

However difficult, this process is a "valuable feature" of our system, "not something to be lamented and evaded." *Id.* The lawmaking process "tend[s] to foster

the fairness and deliberation that should underlie a pronouncement of such force." *United States v. Mead Corp.*, 533 U.S. 218, 230 (2001). From the standpoint of federalism, requiring some measure of formal process "imposes a degree of accountability on decisions which will have the profound effect of displacing state law, and affords some protection to the states that will have their laws displaced and to citizens who may hold rights or expectations under those laws." *Fellner v. Tri-Union Seafoods, LLC*, 539 F.3d 237, 245 (3d Cir. 2008).

These structural safeguards are entirely absent here. Under FEHBA, "the government does not impose contract terms as it would impose a law." *McVeigh*, 396 F.3d at 144. Instead, OPM, acting solely in its capacity as employer and market participant, "negotiates the contract terms privately with insurance providers who are under no obligation to enter into the contracts in the first place." *Id.* (internal citations omitted). And neither the statute nor any regulations allow for judicial review of, or public participation in, the contracting process. *See* 5 C.F.R. § 890.203. This "contract-based participation in the market" simply cannot exert preemptive force under the Supremacy Clause. *Am. Trucking*, 133 S. Ct. at 2102-03 (holding that actions carrying the "force and effect of law" involve "the State acting as State, not as any market actor").

2. To avoid this conclusion, Coventry argues that "all the Supremacy Clause requires" is some general statutory declaration of preemption. Pet. Br. 56. In its view, because § 8902(m)(1) "*itself* declares that the state and local laws it covers" may be preempted by contract, the mechanism of preemption—privately negotiated contract terms—is irrelevant. *Id.* This theory of preemption is wrong. The source of federal law that *actually* preempts state law matters. It "may be federal common law or the FEHBA statute provisions themselves, but it

must be law—not contract terms." *McVeigh*, 396 F.3d at 145. Section 8902(m)(1), by delegating preemption to the content of future contract terms, leaves the particular targets of preemption to the vagaries of private contracts instead of lawmaking by Congress.

Placing the weight of the Supremacy Clause behind "contract terms that Congress decrees—sight unseen—shall 'preempt and supersede' state law is . . . an unprecedented and unjustified intrusion on state sovereignty." Pet. App. 66a. The constitutional "system of dual sovereignty between the States and the Federal Government" is meant to "ensure the protection of our fundamental liberties," *Gregory v. Ashcroft*, 501 U.S. 452, 457-58 (1991), but it would "dash the whole scheme if Congress could give its power away to an entity that is not constrained by [the lawmaking process]," *Dep't of Transp.*, 135 S. Ct. at 1237 (Alito, J., concurring).

Lacking authority to support its theory, Coventry claims that § 8902(m)(1) is "unremarkable" and "commonplace." Pet. Br. 57-58. It says, for instance, that ERISA's express preemption clause "follow[s] the same approach." *Id.* at 58. But ERISA "expressly stat[es] that the statute's provisions preempt state law," *McVeigh*, 396 F.3d at 143. *See* 29 U.S.C. § 1144(a) (providing that "*the provisions of this subchapter and subchapter III* shall supersede any and all State laws" (emphasis added)). The Federal Arbitration Act provides no support either; it "create[s] a body of federal substantive law of arbitrability" that does the preempting. *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983). FEHBA, by contrast, "declares no federal law preemptive," just the terms of an OPM-negotiated contract, and it creates no body of federal common law. *McVeigh*, 547 U.S. at 698 (rejecting the applicability of *Boyle v. United Techs. Corp.*, 487 U.S. 500 (1988)).

Coventry's only other examples duplicate § 8902(m)(1) and are pasted into other sections of its federal-insurance program. *See* 5 U.S.C. §§ 8959, 8989, 9005(a), and 8709(d)(1).[4] These copycat provisions raise the same constitutional concern—a point this Court acknowledged in *Hillman v. Maretta*, 133 S. Ct. 1943, 1949 (2013), when it declined to address the import of the clause in the Federal Employees' Group Life Insurance Act, 5 U.S.C. § 8709(d)(1). Coventry views that case as embracing this form of "unusual" preemption, but there the Court *avoided* resolving the scope of the express preemption clause, instead limiting its analysis to "conflict preemption principles" not presented here. *Id.*

3. The consequences of Coventry's preemption-by-delegation approach extend far beyond this case. If it prevails, FEHB contract terms could (as the Chief Justice hypothesized at oral argument in *McVeigh*) displace any number of state laws, including those limiting usurious interest on contested reimbursement claims or imposing punitive liquidated damages on workers who resist insurer demands to hand over personal-injury settlements. Tr. of Oral Argument at 17, *McVeigh*, 547 U.S. 677 (2006). Contract terms could also override the longstanding make-whole and common-fund rules, allowing insurers to seize entire settlements (and not pay a share of fees incurred to create and preserve the fund)

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[4] Coventry thinks the statute governing health-insurance benefits to uniformed service members, 10 U.S.C. § 1103(a), supports its theory, but Congress's approach there only illustrates the problem here. The original version of § 1103(a) was identical to § 8902(m)(1), but five years later Congress amended it to specifically eliminate the preemption-by-delegation scheme. *Compare* Pub. L. No. 100-180, § 725(a)(1) (1987), *with* Pub. L. No. 103-160, § 715(a) (1993). Though it has not done so, Congress could have taken the same approach here.

even when the recovery is far less than an insured's actual loss. *See, e.g., Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1093-94 (10th Cir. 2015) (OPM contract provides for subrogation and reimbursement "even if the enrollee is not 'made whole' for all damages"). And, on Coventry's approach, state laws that protect against contractually imposed damage caps, distant-forum provisions, and other remedy-stripping clauses could be wiped away as well.

Coventry's preemption-by-delegation theory is also not limited to contracts. If Coventry is correct, Congress could outsource the authority to preempt state law to the yet-undecided (and ever changing) standards of an international body, industry group, NGO, or other private party. Consider a statutory provision stating that "any guidelines issued at any time by the National Meat Association relating to the safe and humane handling of animals for human consumption shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to animal welfare." On Coventry's reasoning, such a clause would raise no Supremacy Clause concern because the clause "itself declares that the state and local laws it covers" are preempted. Pet. Br. 56. True, in such a hypothetical no federal agency has a role in the process (as OPM has here by negotiating the contracts), but that is irrelevant for present purposes. In neither instance is a federal agency exercising valid lawmaking authority that would carry the force of law sufficient to fall within the scope of the Supremacy Clause.

It is no wonder that this Court already deemed § 8902(m)(1) a "puzzling measure" that "warrants cautious interpretation." *McVeigh*, 547 U.S. at 697. Congress is, to be sure, "not disabled" from providing FEHB carriers "protection from state interference," U.S. Br. 30, but it must do so within the limits of the Constitution.

B. FEHBA's express preemption clause cannot be saved by rewriting it.

Coventry and the government suggest that this Court could "save" § 8902(m)(1) by construing it to "giv[e] preemptive effect to federal law—not contracts themselves." Pet. Br. 59; *see* U.S. Br. 28 (suggesting that Congress used the phrase "the terms of any contract" as "an easy[] shorthand," by which "the statute, not the contract itself," preempts state law). But that would require rewriting the unambiguous text of the law. The Court has no power to do that. Congress intended a limited form of preemption by authorizing only certain contract terms to preempt state law, but supplying a different mechanism of preemption—federal law—would unavoidably broaden the preemption regime Congress envisioned. *See Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 252 (2010) (adding a term to a statute "from which it is conspicuously absent more closely resembles 'invent[ing] a statute rather than interpret[ing] one'").

There is no ambiguity about Congress's intent to "render[] preemptive contract terms in health insurance plans, not provisions enacted by Congress." *McVeigh*, 547 U.S. at 697; *see also McVeigh*, 396 F.2d at 151 (Sack, J., concurring) (observing that FEHBA's preemption provision may be "*unavoidably* unconstitutional"). The statute's text says that "[t]he terms of any [FEHBA] contract . . . supersede and preempt" state law. There is no reference to the statute (or regulations promulgated pursuant to it) preempting state law. And giving contract terms preemptive effect was not a shortcut for incorporating positive federal law as preemptive: The two are not the same. All of FEHBA's statutory provisions and regulations are not placed in every carrier's contract. And FEHB contracts may contain prescriptions that ex-

ist nowhere in the statute. Indeed, their terms are not even consistent across contracts. *Compare Helfrich*, 804 F.3d at 1093-94 (disclaiming the "make whole" rule) *with* JA 120-21 (declining to do the same). Those differences, under Congress's current scheme, matter for preemption.

Congress could easily have followed the approach it has taken in virtually every other context, including ERISA, but instead it "unambiguously provid[ed] for preemption by contract," instructing that "certain types of *contract terms* will 'supersede and preempt' state laws in a particular field." *McVeigh*, 396 F.3d at 143. There is, in short, no plausible alternative interpretation here concerning what carries preemptive force; it is contract terms or nothing. *Warger v. Shauers*, 135 S. Ct. 521, 529 (2014) (explaining that constitutional avoidance "has no application in the absence of ambiguity").

II. FEHBA should be interpreted to avoid preempting Missouri's insurance-subrogation law.

The Court need not invalidate § 8902(m)(1) to resolve this case. Taken together, standard tools of statutory construction show that the better reading does not preempt traditional state insurance-subrogation laws.

A. The text of § 8902(m)(1) is ambiguous.

1. By its terms, FEHBA confers preemptive power on "[t]he terms of any contract . . . which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)," and allows these (and only these) contract terms to "supersede and preempt" any state law or regulation "which relates to health insurance or plans." § 8902(m)(1). But as this Court explained in *McVeigh*, whether a "reimbursement clause in a master [FEHBA] contract" falls "within § 8902(m)(1)'s compass" is ambiguous. 547 U.S. at 697.

Section 8902(m)(1)'s "words" are "open to more than one construction." *Id.*

Although the legislative history suggests otherwise, one could conceivably regard a contractual reimbursement clause "as a condition or limitation on 'benefits' received by a federal employee." *Id.* On that view, "the clause could be ranked among" those "'contract terms relating to coverage or benefits' and 'payments with respect to benefits.'" *Id.* (alterations omitted). Section 8902(m)(1) would, on that interpretation, infuse these contractual provisions with preemptive power and permit them to displace state law.

"On the other hand," the Court explained, "§ 8902(m)(1)'s words may be read" to more narrowly confine the type of contract term capable of wielding preemptive force. *Id.* "The Act contains no provision addressing the subrogation or reimbursement rights of carriers," *id.* at 683, and, on its face, § 8902(m)(1) limits its delegation of preemptive power to only those contract terms related to coverage or benefits (and benefits payments). But "a claim for reimbursement ordinarily arises long after 'coverage' and 'benefits' questions have been resolved, and corresponding 'payments with respect to benefits' have been made to care providers or the insured." *Id.* at 697. Section 8902(m)(1)'s prescription, therefore, could be understood "to refer to contract terms relating to the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received, and not to terms relating to the carrier's postpayments right to reimbursement." *Id.* (emphasis in original). These two plausible constructions render the text of FEHBA's preemption clause ambiguous.

2. Coventry nevertheless insists that the text "speaks clearly." Pet. Br. 39. In its view, "[s]ubrogation

and reimbursement clauses . . . fall squarely within Section 8902(m)(1)'s plain terms." *Id.* at 39, 27. But the Court rejected this very argument in *McVeigh*, acknowledging the ambiguity by citing directly to the specific pages of the parties' briefs pressing the competing interpretations. *See* 547 U.S. at 697. Coventry would have this Court ignore what it said then, but even the government concedes that the provision is ambiguous. *See* U.S. Br. 14.

Undeterred, Coventry has recycled the same textual arguments that were rejected by this Court in *McVeigh*. Here are the comparisons:

- Pet. Br. 25-26: arguing that reimbursement clauses relate to "benefits or coverage" because an "enrollee's ultimate entitlement to benefit payments is '*conditioned*' from the outset 'upon providing reimbursement from any later recovery'";
- Pet. Reply Br. at 9, *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006) (No. 05-200): arguing that reimbursement clauses relate to "benefits or coverage" because "benefits payments" "are, at the start, expressly *conditioned* on the enrollee's agreement to comply with the reimbursement provision";
- Pet. Br. 31: arguing that reimbursement clauses relate to "payments with respect to benefits" because "[s]ubrogation and reimbursement recoveries" require the "return" of benefits and so have the "practical effect" of modifying "a prior benefit payment";
- Pet. Reply Br. at 8-9, *McVeigh*: arguing that reimbursement clauses relate to "payments with respect to benefits" because "reimbursement is the return to the Plan of previous payments of bene-

> fits" and so "the benefit payment cannot be separated from the reimbursement obligation."

Neither the words of the statute nor the carriers' textual arguments have changed since this Court considered and refused to accept the same proposed reading a decade ago. The text of the statute was "open to more than one" plausible construction then, and it remains so now. *McVeigh*, 547 U.S. at 697.

3. Coventry again presses ERISA in service of its "plain text" argument. The "texts" of the two preemption provisions, Coventry claims, are "nearly identical," and should be treated the same. Pet. Br. 28. But the texts are meaningfully different. *McVeigh*, 547 U.S. at 698; *see also McVeigh*, 396 F.3d at 147 ("We should be especially reluctant to rely on ERISA-based precedent to justify an expansive interpretation of FEHBA's preemption provision, given the fundamental differences between ERISA and FEHBA.").

ERISA, unlike FEHBA, "purport[s] to render inoperative *any and all* state laws that in some way bear on federal employee-benefit plans" by declaring that "portions" of the statute itself (i.e., federal law) "supersede any and all State law insofar as they may now or hereafter relate to any employee benefit plan." *McVeigh*, 547 U.S. at 698. FEHBA, by contrast, contains no similarly broad preemptive grant. *See id.* Quite the opposite: Section 8902(m)(1) "declares no federal law preemptive, but instead terms of an [OPM]-negotiated contract"—and only certain terms at that—resulting in a more narrowly drawn preemptive sweep. *Id.*

Text aside, Coventry advances a policy reason for importing this Court's interpretation of ERISA here. Coventry speculates that it "is exceedingly unlikely that Congress intended a *broader* role for state law" in the case "of federal employees [for FEHBA] than in the case

of private employees [for ERISA]." Pet. Br. 28. But Congress could have adopted ERISA's preemption provision—drafted less than five years earlier—when it agreed to add a preemption clause to FEHBA in 1978. Instead it opted for a narrower approach. *See McVeigh*, 396 F.3d at 147 (explaining that ERISA's preemption regime "is significantly more comprehensive than FEHBA"). Coventry's plea that this Court "soften the import of Congress' chosen words" is inappropriate. *Lamie v. United States Trustee*, 540 U.S. 526, 538 (2004).

In any case, Coventry's policy argument fails on its own terms because it rests on a misunderstanding of ERISA's treatment of state laws restricting insurance subrogation. Insurance subrogation laws are, as this Court has held, laws that "regulate[] insurance," and, thus, are expressly exempted from ERISA. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990); *see* 29 U.S.C. § 1144(b)(2)(A) (saving from preemption state laws regulating insurance). Adopting a "modest reading" of FEHBA—one that does not abridge state efforts to regulate "the matter of subrogation"—would thus put the two statutes on equal footing, just as Coventry and the government demand.

B. A narrow reading avoids serious constitutional questions and adheres to core federalism principles.

Construing FEHBA in accordance with two longstanding canons of statutory construction—the canon of constitutional avoidance and the presumption against preemption—further comports with this Court's recognition that FEHBA's express preemption clause "warrants cautious interpretation." *McVeigh*, 547 U.S. at 697.

1. "[W]hen deciding which of two plausible statutory constructions to adopt," if "one of them would raise a

multitude of constitutional problems, the other should prevail." *Clark v. Martinez*, 543 U.S. 371, 380-81 (2005). Applying this "cardinal principle" here is straightforward. *Edward J. DeBartolo Corp. v. Florida Gulf Coast Building & Constr. Trades Council*, 485 U.S. 568, 575 (1988). There are "two plausible statutory constructions" of § 8902(m)(1), and the "expansive" one—in which the terms of Coventry's contract unilaterally supersede Missouri's state law—"raise[s] a multitude of constitutional problems." *Clark*, 543 U.S. at 380-81. Adopting the alternative—and explicitly "plausible"—construction "allows [the Court] to avoid the decision of constitutional questions" because there would be no preemption of state law here. *Id.* at 381. Fidelity to this approach is both prudent and correct. *See DeBartolo*, 485 U.S. at 575. It is also the only valid application of the avoidance doctrine that exists in this case. *See supra*, at 25.

2. Reading FEHBA narrowly also accords "respect for the States as independent sovereigns in our federal system," *Wyeth*, 555 U.S. at 565 n.3, and reflects a fundamental recognition that Congress's decision to "legislate in areas traditionally regulated by the States" is "an extraordinary power" that Congress "does not exercise lightly," *Ashcroft*, 501 U.S. at 460. "[I]n all pre-emption cases, and particularly in those in which Congress has legislated in a field which the States have traditionally occupied," this Court starts with the "cornerstone" "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Wyeth*, 555 U.S. at 565 (alterations omitted). The "effect" of this principle is to "support, where plausible, 'a narrow interpretation' of an express pre-emption provision." *CTS Corp. v. Waldburger*, 134 S. Ct. 2175, 2189 (2014) (Kennedy, J., concurring) (quoting *Medtronic, Inc. v.*

Lohr, 518 U.S. 470, 485 (1996)); *see also Bates v. Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005).

Following this command places "the power of preemption squarely in the hands of Congress, which is far more suited than the Judiciary to strike the appropriate state/federal balance." *Geier v. Am. Honda Motor Co., Inc.*, 529 U.S. 861, 907 (2000). By contrast, refusing to exercise caution on questions of preemption jeopardizes the "validity and effectiveness" of state laws that Congress did not intend to displace and a State's own determination of what is "important to its scheme of governance." *See Arizona v. Inter Tribal Council of Ariz. Inc.*, 133 S. Ct. 2247, 2261 (2013) (Kennedy J., concurring).

This "cautionary principle" applies with full force here because the "regulation of insurance, though within the ambit of federal power, has traditionally been under the control of the States." *Arizona*, 133 S. Ct. at 2261 (Kennedy, J., concurring); *Sec. & Exch. Comm'n v. Variable Annuity Life Ins. Co. of Am.*, 359 U.S. 65, 68-69 (1959). As a result, "[w]hen the States speak in the field of 'insurance,' they speak with the authority of a long tradition," requiring that the Court must "start with a reluctance to disturb" any "state regulatory schemes." *Sec. & Exch.*, 359 U.S. at 68. "[W]ithout clear manifestation of congressional purpose," in other words, there can be no preemption of state insurance regulations. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002); *see Wilburn Boat Co. v. Fireman's Fund Ins. Co.*, 348 U.S. 310, 372 (1955) ("The control of all types of insurance companies and contracts has been primarily a state function since the States came into being.").

Given FEHBA's ambiguity, it cannot be said that Congress "clear[ly] and manifest[ly]" intended to preempt state insurance-subrogation laws. *Rice v. Santa*

Fe Elevator Corp., 331 U.S. 218, 230 (1947). The statute must be construed to avoid preemption.

3. Coventry and the government both insist that this federalism principle does not apply in cases interpreting the scope of express preemption clauses. *See* Pet. Br. 37-38; U.S. Br. 11 (citing *Puerto Rico v. Franklin Cal. Tax-Free Trust*, 136 S. Ct. 1938, 1946 (2016)). But the point of cases like *Puerto Rico* is that, where the text of a statute is "plain," the presumption is unnecessary because Congress's "preemptive intent" will be clear. 136 S. Ct. at 1946.

The same is not true where the text itself is open to two plausible constructions. *See Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 533 (1992) (Blackmun, J., concurring in part, concurring in the judgment in part, and dissenting in part) ("The principles of federalism and respect for state sovereignty that underlie the Court's reluctance to find pre-emption where Congress has not spoken directly to the issue apply with equal force where Congress has spoken, though ambiguously."). With ambiguous express preemption clauses, this Court has routinely cited the presumption against preemption. *See, e.g.*, *Altria Group, Inc. v. Good*, 555 U.S. 70, 77 (2008). And that includes the consideration of express preemption clauses in the health-insurance context. *See, e.g.*, *Cal. Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 325 (1997) (applying presumption in case concerning ERISA's clause).

Falling back, the challengers see no reason to consider the presumption because (in their view) FEHBA addressed "an area of overwhelming federal interests with a lengthy history of federal regulation." Pet. Br. 37. But that argument "misunderstands the principle." *Wyeth*, 555 U.S. at 565 n.3. The presumption "accounts for

the historic presence of state law but does not rely on the absence of federal regulation." *Id.*

Coventry's analogy to those cases involving areas of nearly exclusive federal regulation also fails. *See Buckman Co. v. Pls.' Legal Comm.*, 531 U.S. 341 (2001) (policing the "relationship between a federal agency and the entity it regulates" through "fraud-on-the-agency" claims); *United States v. Locke*, 529 U.S. 89, 108 (2000) ("national and international maritime commerce" in which "Congress has legislated . . . from the earliest days of the Republic"). FEHBA's regulatory framework is "poles apart." *McVeigh*, 547 U.S. at 700. Although Congress "establishe[d] a comprehensive program of heath insurance for federal employees," this Court already recognized that it did not "purport to render inoperative *any and all* state laws" bearing on "federal employee-benefit plans in general, or carrier-reimbursement claims in particular." *Id.* at 682, 698-99. To the contrary, Congress made clear that (1) "the States have the authority to both regulate and tax health insurance carriers operating under [FEHBA]," and (2) the fact that carriers "are administering a Federal contract is no reason for circumventing compliance with applicable State laws." Comptroller Report at 15-16 (JA 565-66).

Indeed, this Court could hardly have more clearly rejected Coventry's "uniquely federal" theory (at 37) of FEHBA in *McVeigh*. A carrier's contract-based reimbursement claim, this Court explained, "is not a creature of federal law." *McVeigh*, 547 U.S. at 696 (alterations omitted). Instead, a FEHBA-based "reimbursement claim [is] triggered, not by the action of any federal government, agency, or service, but by the settlement of a personal-injury action launched in state court," and "the bottom-line practical issue is the share of that settlement properly payable to the [insurer]." *Id.* at 681. "[C]laims of this genre, seeking recovery from the proceeds of

state-court litigation, are the sort ordinarily resolved in state courts" and are "plainly governed by state law." *Id.* at 683, 698; *see also id.* at 699 (observing that any subrogation claim would also "be governed not by an agreement to which the tortfeasors are strangers, but by state law").[5]

C. Congress passed § 8902(m)(1) to target specific state-benefit laws and did not intend it to be read expansively.

In the absence of any authoritative textual support for its expansive interpretation of the statute, Coventry turns to the provision's legislative history to discern Congress's "purpose." Pet. Br. 32. Coventry insists that this history "erase[s] any possible doubt" that "FEHBA preempts antisubrogation and antireimbursement laws" because it "enacted" the provision to broadly "combat state-law interference with FEHBA plans." *Id.* at 32-33; *see also* U.S. Br. 11. But Coventry relies almost entirely on recent comments made by OPM, *see* Pet. Br. 33-35, rather than on Congress's own contemporaneous statements made during the § 8902(m)(1)'s enactment and amendment. This congressional-intent-by-agency-proxy theory is a nonstarter. It is the "purpose of *Congress*"

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[5] For this reason, too, the government is wrong to suggest that state law is displaced via federal common law, as in *Boyle*. *See* U.S. Br. 30-31. Not even Coventry makes this argument, and for good reason. *McVeigh* thoroughly rejected the idea that reimbursement claims under FEHBA are "pervasively federal" because "an insurer's contract-derived claim to be reimbursed from the proceeds of a federal worker's state-court-initiated tort litigation" is a "nonstatutory issue" that does not fall under "the complete governance of federal law." *See* 547 U.S. at 696. OPM's regulation does nothing more than reiterate the same "federal interests" this Court rejected a decade ago.

that is "the ultimate touchstone in every pre-emption case." *Lohr*, 518 U.S. at 485. And Congress's own contemporaneous commentary demonstrates that it intended a limited—not "sweeping"—form of preemption.

1. In enacting § 8902(m)(1), Congress said that the clause was "purposely limited" to address state laws that "pertain to coverage and benefits," and not to "provide insurance carriers . . . with exemptions from state laws and regulations" "pertaining to the regulation of insurance within the state." S. Rep. No. 95-903, at 3, 7 (JA 369, 375). This "limited" approach flowed directly from Congress's recognition that only *some* state laws had begun to pose "serious problems" for carriers offering certain nationwide plans. *See supra*, at 7 (discussing laws requiring coverage for, among other things, chiropractor and acupuncture services). Neither CSC nor Congress identified any state antisubrogation laws as posing similar problems—despite the fact that numerous states, including Missouri, had imposed these restrictions on insurers for years. *See supra*, at 12.

Congress carefully tailored § 8902(m)(1) to address benefits issues. Some insurers pushed for a broader preemption clause that would allow entire FEHB contracts to "supersede, or take precedence over" even standard insurance laws. Comptroller Report at 14-15 (JA 565). That position gained no traction. Instead, at the suggestion of the agency, Congress installed a narrower preemption regime, emphasizing that administering a federal health contract "is no reason for circumventing compliance with applicable State laws." *Id.* at 16 (JA 566).

Two decades later, Congress amended the preemption clause but left the basic federal-state balance undisturbed. And, as before, no one—not Congress, the agency, or even FEHB carriers—even *identified* state anti-

subrogation laws as worthy of concern, even though by the late 1990s dozens more states had enacted restrictions on subrogation and reimbursement. *See supra*, at 12; *see also* S. Rep. No. 105-257 at 14-15 (JA 468-69)) (stressing that "the only effect" of the newly amended preemption clause "would be to limit the application of state law in some circumstances"—touching only those "states that have requirements governing what types of organization can provide health care when those requirements are different from those under federal contracts").

3. Against this historical record, Coventry invokes "uniformity" and "cost-cutting" concerns. Like the government, Coventry begins with the claim that Congress's goal was to enable "uniform, nationwide application of FEHB contracts." Pet. Br. 16; *see* U.S. Br. 27. Adopting a narrow interpretation would, in Coventry's view, "thwart" this aim by inviting a "motley patchwork of State-specific restrictions." Pet. Br. 34. But that misstates the purpose of FEHBA's preemption clause, which does not render inoperative *any and all* state laws that in some way bear on federal employee-benefit plans in general, or carrier-reimbursement claims in particular. *See* H.R. Rep. No. 95-282 at 4-5 (JA 356-57). To the contrary, Congress explicitly limited its stated preemption goal to only those laws that the agency and its carriers had identified as problematic—those affecting the "uniformity of benefits to all enrollees." *Id.* at 7 (JA 362). Other laws, including state-specific insurance rules, were intentionally left intact, as a crucial component of FEHBA's dual-regulatory approach. *See id.* at 6 (JA 359).

Coventry's focus on the nearly limitless principle of cost savings also overstates the concerns motivating § 8902(m)(1). *See* Pet. Br. 33-34; U.S. Br. 19-20. "[T]here is no federal policy that the fund should always win" in

cases involving state rules that, if enforced, "might deplete" the government's coffers. *O'Melveny & Myers v. F.D.I.C.*, 512 U.S. 79, 88 (1994). Indeed, this Court has routinely "rejected 'more money' arguments" in cases where Congress has not "set forth any anticipated level for the fund." *Id.*; *see also Yazell*, 382 U.S. at 348-50 (a federal financial interest "to collect moneys which the Government lends" in "an individualized, negotiated contract" is not enough to displace "state law to the contrary").

The weakness of this cost-cutting argument is underscored by the type of plan at issue here. Coventry's plan is community-rated, and so does not credit *any* of its reimbursement recoveries back to the government and does not use those recoveries at all when setting premiums. *See* 48 C.F.R. § 1631.20048; JA134-35 (requiring that rates "be equivalent" to similarly sized private plans in the region).

That is also why Coventry's concern about "cross-subsidization" falls flat. None of the enrollees in its plan—a local HMO available to federal workers living only in Missouri—will be "treat[ed] differently" or subject to nonuniform rules if Missouri's restriction on subrogation "survive[s] preemption." Pet. Br. 35. What would be "unfair" to Coventry's enrollees (to use its word) would be depriving them of a core state-law protection applicable to all insurers doing business in the state.

D. Reading the clause narrowly will not leave OPM powerless to limit state interference.

An interpretation of § 8902(m)(1) that is faithful to Congress's desire to install a limited preemption regime does not, as the government contends, leave OPM "powerless" to limit state interference with the FEHB pro-

gram. It just requires that OPM achieve its desired goals through valid, democratic means.

OPM could, for instance, simply ask Congress to amend § 8902(m)(1) again. The provision was initially enacted in response to a "serious problem[]" that the agency identified. S. Rep. No. 95-903, at 4, 7 (JA 375). And it was amended "based upon" other "concerns raised" by OPM. S. Rep. No. 105-257, at 2-3 (JA 444). Congress has shown a remarkable responsiveness to OPM's concerns over its ability to administer the FEHB program. *See, e.g.*, H.R. Rep. No. 100-917 (1988) (amending FEHBA to address additional OPM concerns). And, as we have explained above (at 23), there is even a clear blueprint, in the form of 10 U.S.C. § 1103, that offers a workable (and legitimate) approach to preemption in the federal-insurance context.

Congress has also previously amended federal law to add a *statutory* provision relating to insurance subrogation. Medicare was amended after "many years [when] courts were divided about the propriety of the federal government's attempts to recover Medicare expenditures . . . in cases involving tort settlement claims." *In re Zyprexa Prods. Liab. Litig.*, 451 F. Supp. 2d 458, 465 (E.D.N.Y. 2006); *see also* H.R. Rep. No. 108-178(II), at 189-90 (2003) (adding statutory amendment to remedy the effects of "recent court decisions" that would allow "firms that self-insure for product liability" to be "able to avoid paying Medicare for past medical payments related to the claim").

III. OPM's interpretation of FEHBA's express preemption clause should not receive *Chevron* deference.

The government opts not to join Coventry's effort to re-litigate the "plain text" meaning of § 8902(m)(1). Instead, it stakes its case for an expansive construction of

§ 8902(m)(1) on a broader theory: that agency interpretations of the scope of express preemption clauses are entitled to *Chevron* deference. U.S. Br. 14, 20. Coventry agrees. *See* Pet. Br. 42-55.

But this Court has never held that an agency—in the absence of an explicit delegation by Congress—receives *Chevron* deference when it interprets the scope of an express preemption provision. *See Lohr*, 518 U.S. at 512 (O'Connor, J. concurring in part and dissenting in part). And for good reason. Principles of federalism and this Court's *Chevron* doctrine itself show that Congress—not an agency—is vested with that power. Embracing the challengers' novel theory of agency power would jeopardize dual sovereignty, the "defining feature of our Nation's constitutional blueprint." *Fed. Maritime Comm'n v. South Carolina Ports Authority*, 535 U.S. 743, 751 (2002).

A. Congress did not authorize OPM to enact regulations expressly preempting state law.

The agency's assertion of *Chevron* deference stumbles right out of the gate: Congress did not delegate to OPM the authority to issue a regulation expanding the scope of FEHBA's express preemption provision.

1. "[A]n agency literally has no power to act, let alone pre-empt validly enacted legislation of a sovereign State, unless and until Congress confers power on it." *Louisiana Public Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986). Were it otherwise, an agency would have the "power to override Congress." *Id.* at 374-75. But lawmaking authority rests with Congress, not agencies, so "[i]t is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority delegated by Congress." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988).

Chevron deference is founded on this principle. A "precondition to deference under *Chevron* is a congressional delegation of administrative authority." *Adams Fruit Co. v. Barrett*, 494 U.S. 638, 649 (1990). What this means is that "*Chevron* deference . . . is not accorded merely because the statute is ambiguous and an administrative official is involved." *Gonzales v. Oregon*, 546 U.S. 243, 258 (2006). Instead, agency interpretations of statutory ambiguities are afforded *Chevron* deference "*because* Congress has delegated to the agency authority to interpret those ambiguities 'with the force of law.'" *City of Arlington v. FCC*, 133 S. Ct. 1863, 1880 (2013) (Roberts, C.J., dissenting) (quoting *Mead*, 533 U.S. at 229). A court, therefore, must inquire "on its own" whether Congress "has in fact delegated to the agency lawmaking power over the ambiguity at issue." *Id.*

Here, that inquiry demonstrates that OPM lacks authority to interpret the ambiguity in FEHBA's express preemption clause. An agency's formal statements on preemption are only entitled to deference if Congress has explicitly "authorized" the agency "to pre-empt state law directly." *Wyeth*, 555 U.S. at 576. And, because Congress "knows how to authorize executive agencies to pre-empt state laws," an explicit authorization is typically not difficult to discern. *Watters*, 550 U.S. at 38 (Steven, J., dissenting, joined by Roberts, C.J., and Scalia, J.). All Congress must do is include some language in the statute specifying that a particular agency has the authority to determine the scope of an express preemption clause or otherwise expressly displace state laws. *See Wyeth*, 555 U.S. at 576 (noting that the FDA was authorized by 21 U.S.C. § 360k(b) to "determine the scope of the Medical Devices Amendments' pre-emption clause"). Consider these few illustrative examples:

- A congressional command that, if the FCC "determines" that a state law violates an express

preemption clause, it shall "preempt the enforcement" of the state law. 47 U.S.C. § 253(d);

- A delegation to the Secretary of Transportation to "issue a decision" on "whether [a state] requirement is preempted" by an express preemption clause and to "prescribe regulations for carrying out" that decision. 49 U.S.C. § 5125(d);
- A specific authorization to the Secretary of the Interior to "set forth any State law or regulation which is preempted and superseded" because it conflicts with "the purposes and the requirements of this chapter." 30 U.S.C. § 1254(g);
- An instruction that state laws "relating to health insurance" are preempted "to the extent that the Secretary . . . determine[s] that" (1) the state law is "inconsistent with a specific provision of the contract," or (2) preemption is "necessary to implement or administer the provisions of the contract or achieve any other important Federal interest." 10 U.S.C. § 1103.

FEHBA, however, contains no such command. Unlike the preceding examples, when Congress enacted FEHBA it included nothing more than a garden-variety instruction to OPM to "prescribe regulations necessary to carry out this chapter." 5 U.S.C. § 8913. That is not enough. *See Wyeth*, 555 U.S. at 576; *compare Lohr*, 518 U.S. at 495-96 (explaining that Congress "explicitly delegated" the agency "a unique role in determining the scope of the [statute's] pre-emptive effect."); *City of New York v. FCC*, 486 U.S. 57, 67-69 (1988) (concluding that Congress gave a "straightforward endorsement" of an agency's exercise of express preemptive authority). Generic rulemaking authority is commonplace in the U.S. Code, but it says not a word about preemption, so there

is simply no evidence that Congress sought to grant the agency power to patrol the state-federal borderline.

2. Requiring that Congress be clear when it intends to lodge authority to expressly preempt state law with an executive agency also serves certain crucial separation-of-powers interests that were not triggered in *Chevron*.

First, *Chevron*'s animating principle of deference rests on "a presumption that Congress, when it [leaves] ambiguity in a statute," is "implicitly" delegating policy questions "for the agency to fill." *Smiley*, 517 U.S. at 740-41; *Chevron, U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 843-44 (1984). That holds particularly for "technical and complex" *policy* questions, over which agencies have "great expertise." *Chevron*, 467 U.S. at 865. But there is no reason to presume that agencies are experts on the "overall distribution of governmental authority and the intrinsic value of preserving core state regulatory authority." Nina Mendelson, *Chevron and Preemption*, 102 Mich. L. Rev. 737, 742 (2004). Agencies may have "a unique understanding of the statutes they administer," *Wyeth*, 555 U.S. at 577, but knowing what a statute actually does is distinct from knowing whether the statute should preempt state law—that is "not a policy judgment within the agency's expertise." Ernest Young, *Executive Preemption*, 102 Nw. U. L. Rev. 869, 889 (2008).

Second, *Chevron* took its cue from the division of decisional authority. The question in *Chevron* was whether Congress would want agencies, rather than "federal judges—who have no constituency"—to make choices that center "on the wisdom of the agency's policy." 467 U.S. at 866. Given that choice, siding with agencies made sense because, "while not directly accountable to the people," agencies are more democratically accountable than courts. *Id.* at 865. But this calculus changes in the

preemption context, where the authority of sovereign states is paramount. Because the "state institution is likely to be both closer to the people and, in the case of state legislatures . . . directly accountable to them," *Chevron*'s "democratic legitimacy justification for deferring to the federal agency simply does not apply." Young at 887. "Put another way, *Chevron* describes how judges and administrators divide power. But power to define [preemption] is not theirs to divide." *Carter v. Welles-Bowen Realty, Inc.*, 736 F.3d 722, 731 (6th Cir. 2013) (Sutton, J., concurring).

Instead, the Constitution places "the power of preemption squarely in the hands of Congress," not unelected bureaucrats. *Geier*, 529 U.S. at 907. And the Framers believed that States, through their representatives in Congress, could play a critical role in drafting legislation and protecting state sovereignty. James Madison explained that the Congress "will partake sufficiently of the spirit [of the States], to be disinclined to invade the rights of the individual States, or the prerogatives of their governments." The Federalist, No. 46 at 297 (James Madison) (Clinton Rossiter ed., 1961); *see also Garcia v. San Antonio Metro Transit Auth.*, 469 U.S. 528, 550 (1985) ("[T]he principal means chosen by the Framers to ensure the role of the States in the federal system lies in the structure of the Federal Government itself.").

3. The government and Coventry nevertheless maintain that FEHBA's generic grant is sufficient. U.S. Br. 22; Pet. Br. 47. In their view, FEHBA's "general conferral of rulemaking authority" entitles the agency to *Chevron* deference over its interpretations of "all of the Act's parts—including its preemption provision." U.S. Br. 22. That sweeping view, however, would silently unlock *Chevron* deference for agency interpretations of express preemption clauses in *any* statute that includes a similar

generic delegation and, in turn, radically shift the source of authority for displacing state law from Congress to the Executive (and executive agencies, no less). Even those lower courts that ruled in favor of preemption here wouldn't agree. *See Bell v. Blue Cross & Blue Shield*, 823 F.3d 1198, 1203 (8th Cir. 2016) (declining to adopt the argument regarding agency authority); *Helfrich*, 804 F.3d at 1109 (same). And if it were true that a "general conferral" clause suffices, then Congress's frequent *specific* delegations to agencies to expressly preempt state law would be unnecessary and redundant.

Consider Coventry's lead case, *City of Arlington v. FCC*, 133 S. Ct. 1863 (2013). Coventry contends (at 48) that it holds that a "'general conferral' of rulemaking authority" automatically hands agencies *Chevron* deference for rules expanding the scope of express preemption clauses because "there are no subject-matter specific exceptions to *Chevron*." Once "an agency is authorized to interpret a statute," Coventry says, that authorization "empowers" agencies "to interpret *every* aspect of the statute"—"including" the scope of express preemption clauses like "Section 8902(m)(1)." Pet. Br. 47-48.

City of Arlington does not bear the weight of Coventry's theory because, as the Court emphasized, the case had "nothing to do with federalism." 133 S. Ct. at 1873. Unlike FEHBA, the statute there "explicitly supplant[ed] state authority." *Id.* So the Court had to determine whether "unelected federal bureaucrats" or "unelected . . . federal judges" were entitled to interpret the scope of a statutory "jurisdiction" provision. *Id.* at 1866. Either way, that question was "not a debate about whether the States [would] be allowed to do their own thing." *Id.*; *see also Cuomo v. Clearing House Ass'n LLC*, 557 U.S. 519, 525, 534 (2009) (refusing to accord *any deference* for the agency's interpretation of an express preemption clause because it was impermissible

and declining to squarely decide whether federalism concerns would have made the agency's effort otherwise invalid).

To ensure that Congress—rather than administrative bureaucrats or unelected judges—yields the power of preemption, courts require a clear statement from Congress. *Lohr*, 518 U.S. at 485. Given that agencies are "clearly not designed to represent the interests of States" and lack any special authority on important issues of state autonomy and federalism, it would be anomalous to assume that Congress would, without saying so explicitly, expect them to pronounce on preemption. *Watters*, 550 U.S. at 41 (Stevens, J., dissenting).

B. OPM's regulation is not a substantive rule entitled to *Chevron* deference.

To say that an agency gets no *Chevron* deference (absent specific congressional delegation) for regulations interpreting the scope of an express preemption clause is not to say that agency regulations can have no *effect* on preemption. This Court has drawn a clear distinction between "question[s] of the substantive (as opposed to preemptive) *meaning* of a statute," and questions over "*whether* a statute is preemptive." *Smiley*, 517 U.S. at 744. A properly promulgated substantive regulation may receive *Chevron* deference and, as a result, displace state law through some form of *implied* preemption. But an agency that issues a regulation expressly displacing state law and argues that a court, in turn, must defer to that pronouncement is on unprecedented footing. Not surprisingly, then, the government recasts OPM's regulation as a run-of-the-mill substantive regulation, and argues that "the only question is a substantive question"—

albeit about the "scope" of § 8902(m)(1). U.S. Br. 24. That is wrong.[6]

1. Substantive questions about the scope of an express preemption clause are still questions about "whether a statute is preemptive." *Smiley*, 517 U.S. at 744. As this Court explained in *Lohr*, when "presented with the task of interpreting a statutory provision that expressly pre-empts state law," although the text establishes that "Congress intended . . . to pre-empt at least some state law," the core preemption "analysis" turns on determining "the scope of the pre-emption statute." 518 U.S. at 484 (interpreting an express preemption clause *requires* "identify[ing] the domain expressly pre-empted"). That the statute expressly preempts *some* laws, in other words, does not (absent clear congressional delegation) free an agency to conclude that it preempts *more* laws.

The Court has already rejected the theory that a regulation can avoid being considered preemptive when it purports "only" to interpret a key phrase in an express preemption clause. In *Cuomo*, the Comptroller claimed that his regulation interpreting the term "visitorial powers" in the National Bank Act's express preemption

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[6] For the same reason, the government reframes OPM's regulation as an interpretation of the meaning of "limitations" on "benefits" under § 8902(d) (stating that FEHB contracts must contain a detailed statement of "limitations" on "benefits"). But (even if applicable), the agency never cited § 8902(d) as a basis for its regulation. Pet. App. 164a. Yet "[i]t is well-established that an agency's action must be upheld, if at all, on the basis articulated by the agency itself." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 50 (1983). And, had OPM issued a regulation defining "limitations" on benefits for purposes of § 8902(d), the argument for preemption would be on an implied, not express, basis. No such argument has been made here.

clause was a nothing more than a substantive regulation that, as in *Smiley*, only produced "practical effect[s]" for preemption. Fed. Resp. Br. at 9, 2009 WL 815241, *Cuomo* (No. 08-453). But, as this Court explained, "[a]ny interpretation of 'visitorial powers' necessarily 'declares the preemptive scope of the NBA'" because the "purpose and function of the statutory term . . . is to define and thereby limit the category of action . . . forbidden to the states." *Cuomo*, 557 U.S. at 535. "If that is not preemption, nothing is." *Id.*

A regulation expanding the category of state laws that must give way, both as a matter of "logic" and "application," is an "incursion upon state powers." *Id.* That is exactly what OPM's regulation seeks to do. By "purport[ing] to settle the scope of federal preemption" through its regulation, OPM has "transform[ed] the preemption question from a judicial inquiry into an administrative *fait accompli*." *Watters*, 550 U.S. at 40 n.24 (Stevens, J. dissenting).

2. Any effort to treat the regulation as "substantive" is also undermined by the *way* in which substantive regulations can preempt. The government is correct that an agency's interpretation of a substantive provision may receive *Chevron* deference even if the interpretation "ha[s] preemptive effect." U.S. Br. 21. But the Court has never "deferred to an agency's *conclusion* that the state law is preempted." *Wyeth*, 555 U.S. at 576. Rather, an agency interpretation of a substantive provision that may have preemptive impact still requires a court to "perform[] its own conflict determination, relying on the substance of state and federal law and not on agency proclamations of pre-emption." *Id.*

That Coventry has declined to advance any argument in favor of implied preemption here discredits the "substantive regulation" theory. Had it genuinely

thought the regulation was substantive, it could have argued that requiring the inclusion of subrogation and reimbursement clauses in all FEHB contracts impliedly preempted state anti-subrogation laws either because they impossibly conflict or frustrate the purposes and objectives of the FEHBA scheme. *See, e.g.*, *Hillsborough Cnty., Fla. v. Automated Med. Labs, Inc.*, 471 U.S. 707, 713 (1985); *Capital Cities Cable, Inc. v. Crisp*, 467 U.S. 691, 705 (1984); *Fidelity Fed. Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 154-59 (1982). In that instance, a court could determine whether there is truly an implied conflict.

C. OPM's interpretation nonetheless fails under *Chevron*.

Evaluating OPM's regulation within *Chevron*'s two-step framework—though inappropriate—reinforces why deference is impermissible here. At both steps, OPM was required to consider the significant federalism implications of its rule expanding the reach of FEHBA's express preemption clause. To claim an entitlement to deference, an agency must take seriously its obligations to thoroughly analyze the questions and meaningfully engage with inconvenient facts or competing principles. Other agencies do. *See, e.g.*, 74 Fed. Reg. 1770, 1792 (2009) (DOT regulation addressing applicability of presumption against preemption). And OPM has too. *See* 59 Fed. Reg. 48,765, 48,767 (1994) (OPM regulation addressing applicability of constitutional avoidance doctrine). Yet OPM's regulation here cast them off entirely, with no explanation. The Court should not reward the agency for such dismissive rulemaking.

1. Under traditional canons of statutory construction, OPM's regulation cannot pass *Chevron* step one.

The "critical" point in any statutory interpretation case is that "[r]ules of interpretation bind all interpreters, administrative agencies included." *Carter*, 736 F.3d at 731 (Sutton, J., concurring). Thus, "[d]eference comes into play only if a statutory ambiguity lingers after deployment of all pertinent interpretive principles," including the traditional canons of statutory construction used to discern Congress's intent. *Id. See also INS v. St. Cyr*, 533 U.S. 289, 320 n.45 (2001) ("We only defer, however, to agency interpretations of statutes that, applying the normal 'tools of statutory construction,' are ambiguous." (quoting *Chevron*, 467 U.S. at 843 n.9)). Put another way, an agency's interpretation of a statute "does not prevail whenever the face of the statute contains an ambiguity." *Carter*, 736 F.3d at 731 (Sutton, J., concurring). Instead, because "traditional presumptions about the parties or the topic in dispute may limit the breadth of ambiguity," they must be considered at *Chevron* step one. *Commonwealth of Massachusetts v. Dep't of Transp.*, 93 F.3d 890, 893 (D.C. Cir. 1996) (Sentelle, J.).

This rule applies to "[a]ll manner of presumptions, substantive canons and clear-statement rules." *Carter*, 736 F.3d at 731 (Sutton, J., concurring) (collecting cases, applying rule of lenity); *see, e.g.*, *Wyeth*, 555 U.S. at 576 (presumption against preemption); *DeBartolo*, 485 U.S. at 574-76 (constitutional avoidance canon). These rules "take precedence over conflicting agency views," *Carter*, 736 F.3d at 731, because if interpretive principles resolve any statutory doubt, "there is, for *Chevron* purposes, no ambiguity in such a statute for an agency to resolve." *St. Cyr*, 533 U.S. at 320 n.45.

Here, two tools of construction, the presumption against preemption and the canon of constitutional avoidance, resolve the textual ambiguity and leave nothing for OPM to resolve.

a. The presumption against preemption, when applied in the face of an ambiguous express preemption clause, forecloses an agency's reliance on statutory ambiguity to unlock *Chevron* deference. That is because "an agency cannot supply, on Congress's behalf, the clear legislative statement of intent required to overcome the presumption against preemption." *Desiano v. Warner-Lambert & Co.*, 467 F.3d 85, 97 n.9 (2d Cir. 2006) (Calabresi, J.), *aff'd by an equally divided court sub. nom. Warner-Lambert Co., LLC v. Kent*, 552 U.S. 440 (2008). The presumption is "in significant part an effort to promote congressional—rather than executive or bureaucratic—deliberation on certain issues, and to cabin executive officials by calling for express legislative authorization." Cass R. Sunstein, *Law and Administration After Chevron*, 90 Colum. L. Rev. 2071, 2114 (1990).

In the government's view, the presumption is inapplicable because applying it to agency interpretations would result in a "one-way ratchet" against preemption. U.S. Br. at 25 (or, as Coventry argues at 21, the presumption would always "trump[]" *Chevron*). But *Chevron* and the presumption are not at odds; *Chevron* accepts that agencies, not courts, should make *policy* choices. But when the choice implicates displacement of state law, the presumption "does not snatch a policy decision from the political branches. It instead insists that the choice to [expressly preempt state law] be made by the first political branch, rather than the second." *Carter*, 736 F.3d at 732 (Sutton, J., concurring). The "ratchet," in other words, is Congress's to control.

b. The canon of constitutional avoidance, too, ends the *Chevron* inquiry at step one. As this Court has explained, the canon constrains an agency's discretion to interpret statutory ambiguities, even when *Chevron* deference would otherwise be due. *DeBartolo*, 485 U.S. at 575; *Solid Waste Agency of N. Cook Cnty. v. U.S. Army Corps of Eng'rs*, 531 U.S. 159, 172-73 (2001). OPM's regulation—which adopts a constitutionally questionable construction of § 8902(m)(1)—is openly at war with this principle. *See DeBartolo*, 485 U.S. at 575 (rejecting agency interpretation where it would not avoid constitutional concerns); *Miller v. Johnson*, 515 U.S. 900, 923 (1995) (rejecting "agency interpretations to which we would otherwise defer when they raise serious constitutional questions").

2. OPM's interpretation of § 8902(m)(1) is unreasonable.

OPM's regulation also fails at *Chevron* step two. To be reasonable, the agency was required to meaningfully deliberate on the federalism (and constitutional) concerns relevant to this case, especially because it switched positions on its power to interpret § 8902(m)(1). Yet the regulation contains no reasoning justifying its cavalier assault on longstanding state laws.

a. An agency's interpretation of an express preemption clause is not "permissible" if it conflicts with "the strong presumption against preemption in matters traditionally regulated by the state." *Massachusetts*, 93 F.3d at 894. "[A]n agency, no less a court, must interpret a doubtful [preemption clause] in favor of [state sovereignty]." *Carter*, 736 F.3d at 731 (Sutton, J., concurring). Deference, in short, "is not abdication." *E.E.O.C. v. Arabian Am. Oil Co.*, 499 U.S. 244, 260 (1991) (Scalia, J., concurring in part and concurring in judgment). It requires, instead, that courts "accept only those agency

interpretations that are reasonable in light of the principles of construction courts normally employ." *Id.* But, without explanation, OPM ignored key canons that bear on this case. This breach of proper interpretation "demand[s]" that the agency interpretation be "reject[ed]." *Massachusetts*, 93 F.3d at 895; *see also Solid Waste Agency*, 531 U.S. at 166-67, 174 (where Congress "chose to 'recognize, preserve, and protect'" state authority to regulate, courts must "reject the request for administrative deference" of a statutory interpretation that would undermine that choice).

b. OPM's inconsistent positions on its preemptive power further undermine the reasonableness of its interpretation. *See Wyeth*, 555 U.S. at 579 (rejecting the unexplained "dramatic change in [agency] position" on preemption).

In the run-up to § 8902(m)(1)'s passage, the agency made clear that FEHBA's general grant of rulemaking authority provided "no legal basis" to issue "regulation[s] restricting the applicability of State laws to FEHB contracts." Comptroller Report at 15 (JA 565). And it told Congress that, despite FEHBA's generic grant to "prescribe regulations to implement th[e] law," the statute "does not give [the agency] clear authority to issue regulations restricting the application of state laws." S. Rep. No. 95-903, at 4 (JA 370). Without any explanation for its shift, OPM now asserts that the same generic grant of authority that precluded agency regulations expressly preempting state laws forty years earlier now specifically authorizes it.

What's more, Congress responded to the agency's repeated assertions that it lacked the requisite preemptive power to effectuate the statute's purposes—adding and amending § 8902(m)(1) as the agency requested. As this Court has explained, where Congress "has affirma-

tively acted" in reliance "on the representations of [an agency] that it had no authority" to regulate, the agency is "preclude[d] . . . from regulating" even if the agency later opts for a "change in position." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 156 (2000); *see also INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n.30 (1987) (rejecting "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation").

* * * *

Given the "sheer amount of law . . . made by [administrative] agencies," *INS v. Chadha*, 462 U.S. 919, 985-86 (1983), the assumption that agencies have the authority to determine the scope of their own preemptive power could have grave consequences for state sovereignty. To earn legitimacy, agency power must emanate from a specific congressional delegation. *Chevron*, 467 U.S. at 843-44. It is crucial that courts safeguard this requirement, especially on questions directly altering the delicate balance between state and federal sovereignty, and especially where (as here) the assertion of agency power would raise serious constitutional problems. This Court should therefore decline OPM's invitation to radically expand the reach of administrative agencies to displace state law.

CONCLUSION

The Missouri Supreme Court's judgment should be affirmed.

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COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ Of Certiorari
To The Supreme Court Of Missouri

REPLY BRIEF FOR PETITIONER

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RULE 29.6 STATEMENT

The corporate disclosure statement contained in the Brief for Petitioner remains accurate.

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REPLY BRIEF FOR PETITIONER

State laws like Missouri's that prevent Federal Employees Health Benefits Act ("FEHBA") carriers from seeking subrogation or reimbursement—as their contracts with the Office of Personnel Management ("OPM") require—directly threaten the uniform, fair, and efficient administration of FEHBA plans. Interpreting FEHBA's express-preemption provision (5 U.S.C. § 8902(m)(1)) to preempt such laws—as its text and purpose compel, and as OPM has reasonably construed it—neutralizes that threat.

Respondent Nevils, however, asks the Court to multiply exponentially the problems such state laws pose. He first proposes *striking down* FEHBA's preemption provision—eliminating express preemption altogether and inviting States to regulate *every* aspect of OPM's contracts. Alternatively, he urges a miserly construction of Section 8902(m)(1) that similarly invites state-law frustration of FEHBA-plan administration. Nevils's invalidate-first, interpret-later strategy is revealing, reflecting the extreme difficulty of squaring the decision below with the statute. Neither his statutory nor his constitutional arguments for allowing States to nullify federal-government contracts for federal-employee benefits have merit.

Nevils concedes that Section 8902(m)(1)'s text does not compel the Missouri Supreme Court's construction. He claims instead that it is ambiguous, and turns immediately to dice-loading default rules to read it narrowly. But Nevils never establishes that FEHBA is ambiguous in any relevant sense. He offers literally *no* analysis of the statutory text, and disregards or dismisses this Court's most pertinent

precedents. His argument hinges entirely on dictum in *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006), which addressed only federal-court jurisdiction and expressly *reserved judgment* on Section 8902(m)(1)'s scope. *McVeigh* certainly did not hold that Nevils's construction is *equally* plausible. Whether *McVeigh* viewed Nevils's reading as colorable is immaterial; the question here is which reading is *correct*.

Whatever ambiguity FEHBA might be thought to contain, moreover, must be resolved in *favor* of preemption under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), given OPM's regulation reasonably construing it to preempt laws like Missouri's. Nevils proposes (at 46) an unprecedented exception to *Chevron* for preemption provisions unless they include a "clear statement" authorizing regulations on preemption. That invented carve-out contravenes this Court's holding that there are "*no* 'exception[s]'" to *Chevron* for particular topics, *City of Arlington* v. *FCC*, 133 S. Ct. 1863, 1871 (2013) (emphasis added) (citation omitted), and its cases applying *Chevron* to preemption provisions lacking any such "clear statement."

Unable to escape *Chevron*'s framework, Nevils asserts that OPM's interpretation of FEHBA is undeserving of deference. Having admitted that OPM's reading is plausible, he faces an uphill climb, and never gains traction. Nevils invokes a presumption against preemption, but this Court's precedent makes clear that that presumption cannot supersede *Chevron*, and that in any event no such presumption even applies to this *express*-preemption provision addressing *federal*-employee benefits under *federal* contracts. Nevils impugns the pedigree of OPM's

decades-old position, but his argument rests on assertions by a prior agency's staff made *before* Section 8902(m)(1) *existed*. He finally tries to leverage his constitutional challenge to a different aspect of the statute to limit its preemptive scope. But his mislabeled constitutional-avoidance argument avoids nothing. As Nevils previously (and rightly) admitted, the question of Section 8902(m)(1)'s constitutionality "is unavoidable." Resp. Cert. Br. 20.

The answer to that constitutional question is clear. Nevils concedes that it is perfectly constitutional for Congress to do what Section 8902(m)(1) does: prevent state laws from applying to particular contracts. Despite his insistence that grand principles of the constitutional structure are at stake, Nevils's position amounts to a hollow drafting rule. In any event, the statute's text and context permit—and the avoidance canon and common sense compel—reading Section 8902(m)(1) as validly giving preemptive effect to federal law.

Nevils, in short, offers no sound reason for distorting or destroying FEHBA's preemption provision. The Court should reverse and hold that FEHBA—by its terms, and as OPM has reasonably construed it—validly prevents state law from nullifying FEHBA contracts' subrogation and reimbursement terms.

I. FEHBA Preempts State Laws That Bar Carriers From Seeking Subrogation Or Reimbursement Recoveries.

OPM's interpretation of Section 8902(m)(1) as preempting antisubrogation and antireimbursement laws is by far the best reading, and at least a reasonable one entitled to deference. Nevils offers no valid basis to reject it.

A. FEHBA Unambiguously Preempts State Laws Restricting Subrogation Or Reimbursement By FEHBA Carriers.

As Coventry showed, FEHBA's text and purposes point unmistakably in favor of preemption. Pet. Br. 23-35. Nevils has no persuasive answer to either.

1. Section 8902(m)(1)'s Text Covers Laws Restricting Subrogation And Reimbursement.

Nevils sidesteps the crucial starting point of preemption analysis: "'the language of the statute itself.'" *Puerto Rico* v. *Franklin Cal. Tax-Free Tr.*, 136 S. Ct. 1938, 1946 (2016) (citation omitted). He concedes (at 27) that Coventry's reading is "plausible," but makes no effort to show that his contrary reading is consistent with, let alone more faithful to, FEHBA's text.

a. Nevils does not deny that "relate to" in preemption clauses "'express[es] a broad pre-emptive purpose'" and requires only a "connection with, or reference to," the preempted topics. *Morales* v. *Trans World Airlines, Inc.*, 504 U.S. 374, 383-84 (1992) (citation omitted). He neither engages with the definitions of "coverage," "benefits," "extent," and "provision" Coventry catalogued, nor explains how subrogation and reimbursement fall outside of them. *Cf.* Pet. Br. 23-24. And Nevils never confronts Section 8902(m)(1)'s separate text shielding from state law FEHBA-contract terms that relate to "*payments with respect to* benefits," 5 U.S.C. § 8902(m)(1) (emphasis added), which independently covers subrogation and reimbursement. *Cf.* Pet. Br. 31-32.

Nor does Nevils dispute this Court's holding that subrogation and reimbursement relate to benefits in

the context of private plans under the Employee Retirement Income Security Act of 1974 ("ERISA"). *See FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-60 (1990). He dismisses ERISA (at 29-30) because of differences between it and FEHBA, but none bears on *FMC*'s reasoning. Nevils notes (at 29) that ERISA preempts "*any and all* State laws" that relate to employee-benefit plans. 29 U.S.C. § 1144(a) (emphasis added). But FEHBA likewise applies to "*any* State or local law ... which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1) (emphasis added). Although FEHBA shields from state law only certain FEHBA-contract terms, including those that "relate to" "benefits," *FMC* held that an antireimbursement law "'relate[d]' to an employee benefit plan" precisely *because* it affected "benefit levels." 498 U.S. at 58-60.

Nevils also never explains why Congress would desire *greater* state-law interference for *federal*-employee benefits than for private plans. He asserts (at 30) that Congress, in enacting FEHBA after ERISA, "opted for a narrower approach," but never explains how or why. And Nevils concedes (*ibid.*) that ERISA is *narrower* in a key respect: It generally *saves* from preemption state laws "regulat[ing] insurance, banking, or securities," 29 U.S.C. § 1144(b)(2)(A)—an exception FEHBA lacks.[1]

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[1] Although ERISA completely preempts state-law *remedies* for claims concerning plans subject to ERISA, *see Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 207-21 (2004), that is not because of its express-preemption provision's breadth; it is because a *separate* provision, 29 U.S.C. § 1132, provides an *exclusive federal cause of action* for ERISA claims. *See Metro. Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 63-67 (1987).

b. Coventry's textual arguments thus stand unrebutted. Nevils nevertheless insists (at 26-28) that FEHBA is "ambiguous" based solely on dictum in *McVeigh*, 547 U.S. 677, which he claims "rejected" Coventry's "textual arguments." But the sole question presented and decided in *McVeigh* concerned federal-court jurisdiction; the Court expressly *declined* to determine Section 8902(m)(1)'s scope—because it did not matter. 547 U.S. at 682-83, 688-701. Nevils recounts (at 26-27) *McVeigh*'s description of alternative interpretations pressed primarily by *amici*. But he omits the punchline: The Court concluded that it "*need not choose* between" them, because federal jurisdiction was lacking either way. *Id.* at 697-98 (emphasis added). *McVeigh* cannot plausibly be read as *resolving* the very question it explicitly *reserved*.

Nevils seizes (at 3, 27) on *McVeigh*'s passing description of those competing interpretations as "plausible" and of Section 8902(m)(1) as "open to more than one construction." 547 U.S. at 697-98. But neither comment constitutes a *holding* that the statute *is* ambiguous. Just as Section 8902(m)(1)'s meaning was immaterial, *a fortiori* its *clarity* was irrelevant also. *Id.* at 698. *McVeigh* should not be misread as gratuitously deciding a separate issue that the Court explained had no bearing on the jurisdictional issue at hand. In context, the Court's recitation of *amici*'s rival readings and its allusion to them *en passant* as "plausible" were merely part of its explanation why it was *not* deciding an issue the litigants disputed.

McVeigh assuredly did not establish that Nevils's and Coventry's constructions are in anything approaching equipoise. "[T]o acknowledge ambiguity"

in the sense that multiple readings of a statute are possible "is *not* to conclude that all interpretations are *equally* plausible." *Gwaltney of Smithfield, Ltd.* v. *Chesapeake Bay Found., Inc.*, 484 U.S. 49, 57 (1987) (emphases added). Undoubtedly because Section 8902(m)(1)'s scope did not matter, *McVeigh* undertook no evaluation of the relative *merits* of either reading—never examining the words' ordinary meaning or pertinent precedents (such as *FMC*). *McVeigh* cannot be read as declaring FEHBA's text an inkblot, with one construction just as good as another.

2. Congress's Purposes Confirm That FEHBA Preempts Antisubrogation And Antireimbursement Laws.

Nevils's claim of ambiguity independently fails because his reading contravenes Congress's purposes. "Ambiguity is a creature not of definitional possibilities but of statutory context," *Brown* v. *Gardner*, 513 U.S. 115, 118 (1994), including which reading of a statute that "seem[s] ambiguous ... produces a substantive effect that is compatible" with Congress's objectives, *United Sav. Ass'n of Tex.* v. *Timbers of Inwood Forest Assocs.*, 484 U.S. 365, 371 (1988). Nevils does not come close to showing how his interpretation is faithful to Congress's aims.

Nevils does not deny that Congress enacted and expanded Section 8902(m)(1) to facilitate cost savings, or that subrogation and reimbursement recoveries yield more than $100 million annually that his position allows States to wipe out. *Cf.* Pet. Br. 33-35; U.S. Br. 19. He answers (at 37-38) that Congress did not pursue that purpose exclusively, but Nevils cites

no countervailing purpose that plausibly might have persuaded Congress to forgo these savings entirely.[2]

Nevils similarly does not deny Congress's goal of ensuring uniform rules to govern plans. *Cf.* Pet. Br. 33-34; U.S. Br. 19-20. He rejoins (at 37) that laws restricting subrogation and reimbursement are not among the specific examples mentioned in the legislative history, which he mistakenly holds out as the only permissible reach of Section 8902(m)(1). But "[i]t is not the law that a statute can have no effects which are not explicitly mentioned in its legislative history"—especially where (as here) the statutory text "plainly embraces criteria of more general application." *Pittston Coal Group* v. *Sebben*, 488 U.S. 105, 115 (1988). Nevils's revisionist history, moreover, ignores the government's showing that antisubrogation and antireimbursement rules are "indistinguishable ... from the state mandated-benefit laws that Congress enacted the preemption provision to target" in relevant respects: They "creat[e] the same kind of disuniformity, increased costs, and unfair cross-subsidization" as laws mandating particular benefits. U.S. Br. 20; Pet. App. 179a. Nevils never shows otherwise; rather, he urges (at 35-36) ignoring

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[2] Nevils incorrectly asserts (at 38) that cost savings are not implicated here because Coventry's plan was "community-rated" and did not remit recoveries directly to the Treasury. As the government has explained, community-rated carriers' recoveries *do* "lower subscription charges"; their premiums "generally depend on the expected cost of providing benefits," and recoveries "tend to reduce those expected costs, and thus the premiums." Pet. App. 170a-71a; *see also* OPM, *Community Rating Guidelines* 6, 11 (2015), http://tinyurl.com/zfwvhdt ("claims must be reduced by income attributed to FEHBP group enrollees from all other sources such as ... subrogation").

OPM's insights because only Congress's purposes control. But the agency's expertise and experience administering FEHBA for decades surely are relevant in determining which state laws *implicate* Congress's undisputed practical concerns.

Nevils downplays the continuing importance of uniformity, observing (at 4) that "there is no single" provider or plan. He misunderstands the uniformity Congress desired: It was concerned not that different *plans* exist, but that the *laws* governing the *same* plan varied across state lines. *See, e.g.*, H.R. Rep. No. 94-1211, at 3 (1976) (J.A.338). It may well make sense to tailor plans to particular markets or participant pools; Congress left that choice to OPM, which has adopted many different plans. But Congress desired a single, stable set of *legal rules* against which OPM could craft plans to meet different needs.

This case illustrates why. Administering multi-State or nationwide plans is exceedingly difficult if every State's courts or legislature can impose parochial restrictions on whether and how carriers may pursue recoveries that their contracts with OPM require—restrictions subject to change at any time, with alleged violations potentially prompting (as here, J.A.262) class actions seeking punitive damages. And if plans are subject to different subrogation and reimbursement laws of multiple States—like Coventry's plan, available (contrary to Nevils's contention (at 38)) in parts of Missouri *and* Illinois (Pet. App. 145a), whose laws differ, AHIP Br. 18-20—some participants will unfairly bear the cost of special benefits afforded only to others. U.S. Br. 17-18, 20. *That* is the type of disuniformity Congress sought to eliminate, but which Nevils's reading would ensure.

B. OPM's Reasonable Interpretation Of FEHBA Is Entitled To Deference.

Nevils's attempt to manufacture ambiguity ultimately does not help him because, even if his construction were *also* plausible, *OPM's* interpretation in its regulation is at least reasonable and controls under *Chevron*. Nevils and his *amici* attempt to escape *Chevron* altogether, but their contentions run headlong into this Court's precedent. Nevils's fallback arguments that OPM's interpretation of *this* statute deserves no deference have no substance.

1. *Chevron* Applies To OPM's Rule Interpreting Section 8902(m)(1).

Nevils and a minority of States—Missouri notably *not* among them—contend that *Chevron* does not apply at all because (they say) Congress did not authorize OPM to issue regulations addressing preemption. That contention is foreclosed by the statute and this Court's precedent.

a. Nevils and his *amici* insist that OPM lacks authority to opine on preemption because FEHBA lacks a "clear statement" *specifically* authorizing regulations on preemption. Resp. Br. 44-46; States Br. 9-16; NGA Br. 11-20. That contravenes *City of Arlington*, which held that *Chevron* "validate[s] rules for *all* the matters the agency is charged with administering." 133 S. Ct. at 1874. Because "the whole includes all of its parts," that includes everything within the scope of a general grant of rulemaking authority. *Ibid.* There are "no 'exception[s]'" for particular topics, period. *Id.* at 1871 (citation omitted). Section 8913(a)'s authorization to OPM to "prescribe regulations necessary to carry out this

chapter," *i.e.*, *all* of FEHBA, thus includes Section 8902(m)(1).

Nevils dismisses *City of Arlington* (at 45) as inapplicable to "federalism" issues, but its central point was that there are *no* exceptions to *Chevron*. Creating a subject-specific carve-out to *City of Arlington itself* would eviscerate its holding. Nevils notes (*ibid.*) the Court's statement that the case had "nothing to do with federalism," but in context that statement further undermines his position: The Court *rejected* an argument that "*Chevron* deference [was] inappropriate" because the agency "'asserted jurisdiction over matters of traditional state and local concern.'" 133 S. Ct. at 1873 (citation and brackets omitted). That "faux-federalism argument" misunderstood the issue: The federal statute "explicitly supplant[ed] state authority" to *some* extent; the case was thus "'a debate not about whether the States will be allowed to do their own thing, but about whether it will be the FCC or the federal courts that draw the lines to which they must hew.'" *Ibid.* (citation omitted). Here, too, Section 8902(m)(1) "explicitly supplants state authority"; the only question is to what extent. *Ibid.* Whether this Court defers to OPM's view on that issue or decides FEHBA's scope *de novo* "has nothing to do with federalism." *Ibid.*

b. Nevils's contrived "clear statement" rule also contradicts this Court's decisions addressing preemption provisions specifically. He does not dispute that *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735 (1996), accorded *Chevron* deference in addressing 12 U.S.C. § 85, which this Court had already held preempted state law. 517 U.S. at 743-44. Yet *Smiley* did not search for any statutory "clear statement" authorizing the agency to opine on preemption. The

statutes in force were general grants of authority. *See* 12 U.S.C. §§ 1, 93a (1996).

Citing the distinction *Smiley* drew concerning "question[s] of the substantive (as opposed to preemptive) *meaning* of a statute," 517 U.S. at 744, Nevils argues (at 46-47) that only "substantive regulation[s]" merit deference. But he fundamentally misconceives *Smiley*'s point. The Court explained that, where "there is no doubt that [a statute] preempts state law"—true in *Smiley* because this Court had already so held, and true here because Section 8902(m)(1) expressly displaces state law—the *extent* of preemption *is* a matter of its "substantive" rather than "preemptive" meaning, so *Chevron* indisputably *does* apply. 517 U.S. at 744. Nevils's assertion that "[s]ubstantive questions about the scope of an express preemption clause are still questions about 'whether a statute is preemptive'" (Resp. Br. 47 (citation omitted)) erases *Smiley*'s distinction, equating the two questions this Court distinguished.

Nevils's theory, moreover, contradicts *Smiley*'s result. He says (at 46) that "substantive regulation[s]" only "displace state law through some form of *implied* preemption." But there was nothing implicit about the regulation's preemptive effect in *Smiley*: It appeared in a subpart titled "Preemption," it defined "[t]he term 'interest' as used in 12 U.S.C. § 85" (which this Court had held preempted state law), and it was adopted specifically to clarify the scope of preemption in light of ongoing litigation, including *Smiley* itself. 61 Fed. Reg. 4849, 4858 & n.5, 4969

(Feb. 9, 1996). Yet *Smiley* had no difficulty deferring to that regulation.[3]

Nevils's clear-statement test similarly cannot be squared with *Cuomo* v. *Clearing House Association*, 557 U.S. 519 (2009). As he acknowledges (at 48), the regulation there determined the scope of preemption, because "any interpretation of 'visitorial powers' necessarily 'declares the preemptive scope of the [statute].'" 557 U.S. at 535. And "[b]y its clear text" the regulation barred certain actions by States. *Id.* at 525. Yet without identifying any grant of rulemaking authority specifically addressing preemption, this Court expressly applied "the familiar *Chevron* framework." *Ibid.* Nevils writes off *Clearing House* (at 45-46) because the Court did not ultimately *accept* the agency's interpretation. But it did so only because, as the Court explained, that particular interpretation was *unreasonable*. 557 U.S. at 525. Nevils cannot explain why the Court applied "the familiar *Chevron* framework" in the first place.

Nevils seeks refuge in *Wyeth* v. *Levine*, 555 U.S. 555 (2009), but neither *Chevron* nor any express-preemption provision was at issue. *Id.* at 567-68. *Wyeth* acknowledged, moreover, that "an agency regulation with the force of law can pre-empt conflicting state requirements"; the case simply presented "no such regulation." *Id.* at 576. At stake instead was an agency's "mere assertion that state law is an

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[3] Even if Nevils were correct (at 48) that an agency's "*conclusion*" on preemption does not merit deference, that would not matter here. While the second sentence of 5 C.F.R. § 890.106(h) concludes that certain state laws are preempted, its *first* sentence asserts only OPM's interpretation of Section 8902(m)(1)'s scope, and thus is entitled to deference even on Nevils's view.

obstacle to achieving its statutory objectives." *Ibid.* Only in addressing "what weight" to accord that "mere assertion" did the Court note that "Congress ha[d] not authorized the [agency] to pre-empt state law directly." *Ibid.* *Wyeth* has no bearing on whether *Chevron* applies to regulations construing express-preemption provisions.[4]

c. Nevils never addresses the incongruous consequence of his position: that agencies construing statutes that expressly preempt state law receive *less* deference than agencies issuing *freestanding* regulations that independently preempt state law. *Cf.* Pet. Br. 54-55. He does not dispute that "'[f]ederal regulations'" that preempt state law of their own force "'have no less pre-emptive effect than federal statutes.'" *Capital Cities Cable, Inc.* v. *Crisp*, 467 U.S. 691, 699 (1984) (quoting *Fid. Fed. Sav. & Loan Ass'n* v. *de la Cuesta*, 458 U.S. 141, 153-54 (1982)). And he does not deny that no "'presumption against pre-emption'" applies in that setting. *New York* v. *FERC*, 535 U.S. 1, 18 (2002) (citation omitted).

Nor could Nevils claim that these principles apply only where Congress specifically authorizes preemptive regulations. *de la Cuesta* held that "[a] pre-emptive regulation's force does *not* depend on express congressional authorization to displace state law." 458 U.S. at 154 (emphasis added). And both *Capital Cities* and *New York* upheld preemptive

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[4] Likewise, in *Gonzales* v. *Oregon*, 546 U.S. 243 (2006), the statute "d[id] not grant ... broad authority to promulgate rules," *id.* at 259, and the regulations did not construe an express-preemption provision, *id.* at 256-69. The statute also disclaimed any "'intent ... to occupy the field.'" *Id.* at 251 (citation omitted).

regulations based on the agency's general authority over a field, not based on statutes specifically addressing preemption. *See Capital Cities*, 467 U.S. at 699-700; *New York*, 535 U.S. at 18-19. Given the latitude agencies have in exercising general rulemaking authority to preempt state law where Congress has *not* spoken on preemption, it makes no sense to afford *less* deference where Congress *has* expressly chosen to preempt state law, and the agency merely interprets the scope of that preemption.

2. Nevils's Challenges To OPM's Interpretation Of FEHBA Fail.

Unable to escape *Chevron*'s settled framework, Nevils variously attacks OPM's interpretation as foreclosed at *Chevron*'s first step or unreasonable at its second. None of his attacks hits the target.

a. Nevils contends (at 31-35, 51-53) that a presumption against preemption precludes deferring to OPM. But as *Smiley* squarely held, that "'presumption'" does not "in effect trum[p] *Chevron*." 517 U.S. at 743-44. That presumption, moreover, has no application to Section 8902(m)(1).

This Court made clear last Term that no presumption against preemption applies in construing *express*-preemption provisions such as Section 8902(m)(1). *Franklin*, 136 S. Ct. at 1946; Pet. Br. 36-37; U.S. Br. 11; U.S. Chamber Br. 5-13. Nevils tries to rewrite *Franklin*, arguing that it merely deemed the presumption "unnecessary" because the statutory text was "'plain.'" Resp. Br. 33 (citation omitted). That reading contradicts this Court's opinion, which held that "because the statute '*contain[ed]* an express pre-emption clause,'" the Court "d[id] not invoke any presumption against pre-emption." 136 S. Ct. at

1946 (emphasis added). The *existence* of the express-preemption provision displaced the presumption, irrespective of its plainness. *Ibid.* Nevils cites (at 33) pre-*Franklin* cases that he says applied a different approach, but *Franklin*'s categorical holding put any uncertainty on this point to rest.

Nevils also does not deny the extensive history of *federal* involvement regulating *federal*-employee benefits, which independently precludes the presumption. *See United States* v. *Locke*, 529 U.S. 89, 108 (2000). He again distorts (at 34) this Court's precedent, misreading *Locke* as addressing only fields subject to "nearly exclusive federal regulation." *Locke* held, however, that "an 'assumption' of nonpreemption is not triggered when the State regulates in an area where there has been a history of *significant* federal presence," not near-*exclusive* federal control. 529 U.S. at 108 (emphasis added). That makes perfect sense: A "significant" history of federal involvement shows that Congress deliberately entered and remained in a field, removing any worry that preemption might be accidental.

Nevils similarly fails to refute the overriding *federal* interest in efficient and fair administration of *federal* workers' benefits—which further forecloses the presumption. *See Buckman Co.* v. *Plaintiffs' Legal Comm.*, 531 U.S. 341, 347 (2001). He concedes (at 34) that the federal interest in *Buckman*—regulating the "relationship between a federal agency and the entity it regulates," *ibid.*—renders the presumption inapplicable. Section 8902(m)(1) concerns that same relationship, between OPM and carriers with whom it contracts, and who are subject to OPM's regulations and guidance.

Nevils retreats again (at 34-35) to *McVeigh*, claiming that it establishes that FEHBA does not implicate overriding federal interests. But *McVeigh* held only that federal law did not *completely* displace all state law touching the field so as to create exclusive federal-court *jurisdiction*. 547 U.S. at 689-701. Nevils's view that the presumption applies unless federal law has already completely preempted *all* state law in the field is irreconcilable with *Buckman*, which did not involve complete preemption at all.

Nevils and his *amici* alternatively try to redefine the relevant field as state insurance or tort law. Resp. Br. 31-32; AAJ Br. 12-25; Professors' Br. 21-26; MATA Br. 5-9. But the field that the displaced *state* laws regulate is irrelevant. Preemption "is a question of *congressional* intent." *English* v. *Gen. Elec. Co.*, 496 U.S. 72, 78-79 (1990) (emphasis added). It is thus the field in which *Congress* legislates that matters in deciding whether to presume that Congress did not intend to displace state law. Thus, in *Buckman*, while the plaintiffs asserted "state tort law" claims, this Court held that "no presumption against pre-emption obtain[ed]" because the *federal* statute addressed an area of overwhelmingly federal concern. 531 U.S. at 343, 347-48.

FEHBA similarly regulates a distinctly federal field: federal-employee benefits. Section 8902(m)(1) does not sweep aside state insurance or tort law generally; it merely precludes those laws' application to FEHBA contracts. There is no reason to impute to

Congress apprehension about preempting state laws intruding on that inherently federal field.[5]

b. Nevils next asserts (at 53-54) that OPM has taken "inconsistent positions." "Agency inconsistency," however, "is not a basis for declining to analyze the agency's interpretation under the *Chevron* framework," *Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 981 (2005), nor a basis for more searching review of agencies' reasoning, *see FCC* v. *Fox Television Stations, Inc.*, 556 U.S. 502, 514-15 (2009). Nevils's claim of inconsistency, moreover, is pure fiction.

Nevils remarkably alleges (at 14) that until 2015 OPM "had consistently taken the position" that it lacked authority to construe FEHBA to preempt antisubrogation and antireimbursement laws. Yet he identifies not a single statement by OPM since Section 8902(m)(1)'s enactment in 1978 that remotely supports that claim. The only OPM statement he cites (*ibid.*) is its 2012 guidance letter to carriers. But that letter explained that OPM had "consistently

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[5] Repackaging this argument, Nevils claims (at 49, 52-53) that OPM never "considered" its regulation's "federalism implications." But OPM addressed that issue, reasonably concluding that the regulation has no "federalism implications" because it merely "restates existing rights, roles and responsibilities of State ... governments" and "formalize[d] [OPM's] longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978." OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29,203, 29,204 (May 21, 2015) (Pet. App. 162a-63a). Nevils and his *amici* can hardly complain about the length of the final rule's discussion of federalism: None elected to participate in the rulemaking to raise such concerns. *See id.* at 29,203-04 (Pet. App. 160a-63a).

recognized" that FEHBA *does* preempt antisubrogation and antireimbursement laws, and that OPM "continue[d] to maintain this position." OPM, FEHB Program Carrier Letter No. 2012-18, at 2 (June 18, 2012) (Pet. App. 118a). Contrary to Nevils's assertion (at 14), nothing in that letter "acknowledge[d] [OPM's] lack of authority to issue a regulation targeting state law." It did not address OPM's rulemaking authority; that OPM did not yet elect to *exercise* that authority is hardly an admission that no such authority existed.

Nevils's claim of supposed inconsistency rests instead (at 53) on statements by attorneys of OPM's predecessor (the now-defunct Civil Service Commission)—made *before Section 8902(m)(1)'s enactment*—doubting the Commission's ability to issue regulations regarding preemption. Those statements by another agency's staff before FEHBA's preemption provision *existed* do not remotely demonstrate any about-face by OPM. Indeed, it was precisely the Commission's doubts of its "clear authority" to issue regulations addressing preemption that prompted Congress in 1978 to enact Section 8902(m)(1), which Congress adopted to "clear up the doubt and confusion" by "clarify[ing] the Federal Government's and the Civil Service Commission's authority" on this question. S. Rep. No. 95-903, at 4 (1978) (J.A.369-70). OPM, created the same year, has interpreted the statute consistently ever since.

c. Nevils finally claims (at 30-31, 52) that the constitutional-avoidance canon compels rejecting OPM's interpretation. But that principle provides no basis for the distortion of FEHBA he proposes.

The avoidance canon applies only where one of two otherwise-plausible constructions of a statute

raises "'grave and doubtful constitutional questions'" that the other construction would "'avoid.'" *Pa. Dep't of Corr.* v. *Yeskey*, 524 U.S. 206, 212 (1998) (citation omitted). The putative constitutional concern Nevils asserts—that Section 8902(m)(1) violates the Supremacy Clause by stating that "terms of [FEHBA] contract[s] ... shall supersede and preempt" state laws—is illusory. Pet. Br. 56-61; *see also infra* pp. 21-24. Even if that concern were real, it is easily resolved by construing that text as giving preemptive effect to "'*federal law*.'" *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 396 F.3d 136, 144-45 (2d Cir. 2005), *aff'd*, 547 U.S. 677; Pet. Br. 59-60. That sensible reading of the purportedly problematic statutory phrase obviates any constitutional concern.

Nevils, however, does *not* ask the Court to choose between competing interpretations of the statutory text he claims is unconstitutional. Rather, based on his concern about FEHBA's text linking preemption to contract terms, Nevils asks the Court (at 31, 52), to bend *other* language in the statute: the words defining *which* FEHBA contract terms are shielded from state law. Nevils cites no authority for distorting one statutory phrase that raises no constitutional concerns simply to sidestep a constitutional question about *other* language. That approach, moreover, makes no sense. The canon is "a means of giving effect to congressional intent," based on the "reasonable presumption that Congress did not intend" an "interpretatio[n] of a statutory text" that "raises serious constitutional doubts." *Clark* v. *Martinez*, 543 U.S. 371, 381-82 (2005). There is no basis to presume that Congress intended courts to adopt a narrow, illogical reading of mundane terms like "benefits" and "coverage" that raise *no* "constitution-

al doubts," merely to forestall answering constitutional questions about *other* language.

Indeed, Nevils's supposed saving construction does not save Section 8902(m)(1) from the alleged infirmity. His Supremacy Clause claim encompasses *all* of Section 8902(m)(1)'s applications; if meritorious, it would mean FEHBA expressly preempts *no* state laws, not even those indisputably related to coverage and benefits. Reading Section 8902(m)(1) not to reach antisubrogation and antireimbursement laws would do nothing to avoid the supposed constitutional quandary. It would simply dodge that question in one case, leaving that constitutional issue that affects myriad aspects of FEHBA plans in dire need of an answer. The Court should not twist unrelated parts of Section 8902(m)(1) to delay the inevitable adjudication of its constitutionality, but should confront that constitutional question head-on.

II. FEHBA'S EXPRESS-PREEMPTION PROVISION COMPORTS WITH THE SUPREMACY CLAUSE.

Nevils's submission confirms that his constitutional attack is insubstantial. He contends (at 19-24) that Section 8902(m)(1) violates the Supremacy Clause because the FEHBA-contract terms it shields from state-law interference are not *themselves* "Laws of the United States." U.S. Const. art. VI, cl. 2. But Section 8902(m)(1) itself—which declares state laws "supersede[d] and preempte[d]"—*is* a "Law"; it thus is *Congress* that chose whether and what to preempt, referring to certain FEHBA-contract terms simply to make room for them to operate. Indeed, given that FEHBA concerns only federal-government contracts, States' authority over them is doubtful at best. Pet. Br. 59; U.S. Br. 30-31. Congress assuredly can confirm expressly the limit of States' ability to interfere.

Nevils's true complaint (at 22) is that Section 8902(m)(1) improperly "delegate[s] preemption to the content of future contract terms," which he repeatedly but misleadingly describes (at 2, 17, 21) as "privately negotiated" agreements. That supposed "delegat[ion]" to "privat[e] negotiat[ions]" is a fabrication. FEHBA concerns only particular terms (relating to coverage, benefits, and benefit payments) of contracts written by and entered into with *a federal agency*—within parameters set by statute and OPM regulations, 5 U.S.C. §§ 8902-8903, 8913(a), subject to "such maximums, limitations, exclusions, and other definitions of benefits" OPM deems "necessary or desirable," *id.* § 8902(d). Nevils admits (at 41-42) that Congress may validly empower federal agencies to decide the proper scope of preemption (and he has never asserted, below or in this Court, that FEHBA fails to supply an intelligible principle). He never explains why it causes greater constitutional concern for Congress to authorize OPM to make those same determinations in federal contracts.

In any event, Nevils concedes that Congress validly can and does shield even *private* contracts from state-law interference. He admits (at 22) that ERISA, 29 U.S.C. § 1144(a), and the Federal Arbitration Act, 9 U.S.C. § 2—each of which insulates particular private contracts from state laws—comply with the Supremacy Clause. Nevils asserts that those statutes differ because they give preemptive effect to a body of "'federal substantive law.'" Resp. Br. 22 (citation omitted). But he misses the critical common feature: Those statutes, like FEHBA, make preemption *contingent* on the existence and content of particular (future) contracts.

Nevils, moreover, gives the game away by admitting (at 23 n.4) that another federal-benefits statute, 10 U.S.C. § 1103(a)—addressing military servicemembers' medical and dental benefits—is perfectly constitutional. Section 1103(a) provides that "[a] law or regulation of a State or local government relating to health insurance, prepaid health plans, or other health care delivery or financing methods *shall not apply to any contract* entered into" by the Department of Defense under this federal program, so long as the agency determines either that the state law "is inconsistent with" the contract or that preemption is "necessary to implement or administer" the contract or to "achieve any other important Federal interest." *Id.* § 1103(a)(1)-(2) (emphasis added). Nevils concedes that Section 1103(a) is valid. Resp. Br. 23 n.4 ("Congress could have taken the same approach in" FEHBA). But Section 1103(a) does not explicitly state that "federal substantive law" displaces state law; it simply forbids state laws from "apply[ing]" to certain contracts. That undisputedly valid statute is substantively indistinguishable from FEHBA.

Nevils's Supremacy Clause challenge thus boils down to empty semantics, and his grand constitutional principle is a mere drafting rule: If Section 8902(m)(1) said state laws "shall not apply to" certain FEHBA-contract terms, rather than saying those terms "supersede and preempt" state law, his constitutional objection concededly collapses. His argument is not about the constitutional structure or fundamental limits of Congress's power, but a trifling, misplaced quibble over statutory syntax.

There is no reason to strike down Section 8902(m)(1) based on that superficial detail—and ample reason to read FEHBA sensibly to preserve its

validity, as every court besides the court below has done. Pet. Br. 60. Contrary to Nevils's assertion (at 25), construing the statute as giving preemptive force to federal law does not require "rewriting" it. The legal effect of its language is the same as the formulation Nevils approves: Prescribing that state laws "shall not apply to" certain contract terms is precisely what it *means* for those contract terms to "supersede" such laws. Section 8902(m)(1) does not displace state law generally, but merely shields specific contracts from those laws' operation.

Section 8902(m)(1) certainly *can* bear that construction—and the constitutional-avoidance canon Nevils champions thus compels adopting it. So does any rational view of Congress's intent. Nevils's position would mean that Section 8902(m)(1) expressly preempts *nothing*—not even laws at the core of "coverage" and "benefits," including mandated-benefits laws that prompted its enactment. That would leave the administration of millions of federal workers' and dependents' benefits at the mercy of fifty States' courts and legislatures. Unfettered state interference on that scale could make the FEHBA Program utterly unmanageable and incalculably costly. It is inconceivable that the Congresses that enacted and broadened Section 8902(m)(1) intended that result, which renders the provision a nullity. This is thus a paradigmatic case where the avoidance canon "give[s] effect to congressional intent" (*Martinez*, 543 U.S. at 382) by avoiding a construction Congress could not possibly have preferred.

CONCLUSION

The Missouri Supreme Court's judgment should be reversed.

Respectfully submitted.

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v.

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ON WRIT OF CERTIORARI TO THE SUPREME COURT OF MISSOURI

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTIONS PRESENTED

The federal government provides health insurance to federal workers pursuant to the Federal Employees Health Benefits Act of 1959, 5 U.S.C. 8901 *et seq.* The Act authorizes the federal government to offer benefits and impose "limitations" and "other definitions of benefits." 5 U.S.C. 8902(d). The Act further provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law" relating to health insurance. 5 U.S.C. 8902(m)(1). Federal regulations provide that subrogation or reimbursement terms in such a contract impose a "condition of and a limitation on" benefits and benefits payments, "relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits)," and "are therefore effective notwithstanding any state or local law" relating to health insurance. 5 C.F.R. 890.106(b)(1) and (h). The questions presented are:

1. Whether a carrier may seek subrogation or reimbursement pursuant to the terms of its contract with the federal government, under 5 U.S.C. 8902(m)(1), notwithstanding state law prohibiting insurance subrogation.

2. Whether Section 8902(m)(1) is consistent with the Supremacy Clause, U.S. Const. Art. VI, Cl. 2.

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v.

JODIE NEVILS

ON WRIT OF CERTIORARI TO THE SUPREME COURT OF MISSOURI

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF THE UNITED STATES

The federal government provides health insurance to federal employees, retirees, and their dependents, under the Federal Employees Health Benefits Act of 1959 (FEHB Act or Act), 5 U.S.C. 8901 *et seq.* This case presents the questions (i) whether subrogation or reimbursement clauses in FEHB contracts are effective under the Act's preemption provision, 5 U.S.C. 8902(m)(1), notwithstanding state law prohibiting insurance subrogation; and (ii) whether Section 8902(m)(1) is constitutional.

The United States has a substantial interest in the resolution of those questions. The federal government provides health benefits to more than eight million federal employees, retirees, and dependents under the FEHB program. 80 Fed. Reg. 29,203 (May 21, 2015). "The government's share of FEHB premiums in 2014

was approximately $33 billion." *Ibid.* "FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries," which "translate to premium cost savings for the federal government and FEHB enrollees." *Ibid.* The federal government also has a "strong * * * interest" in ensuring that it can administer the FEHB program on a uniform basis, without variation based on a patchwork of state and local laws. 80 Fed. Reg. 932 (Jan. 7, 2015). At the Court's invitation, the Solicitor General filed an amicus brief on behalf of the United States at an earlier stage in this case. 135 S. Ct. 323 (2014).

STATEMENT

1. The FEHB Act "establishes a comprehensive program of health insurance for federal employees." *Empire Healthchoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677, 682 (2006). Today, more than eight million federal workers, retirees, and dependents are enrolled in FEHB plans. 80 Fed. Reg. at 29,203.

The Act vests the Office of Personnel and Management (OPM) with broad authority to administer the FEHB program, see 5 U.S.C. 8901-8913, and to promulgate regulations necessary to carry out the Act's objectives, 5 U.S.C. 8913. OPM contracts with private insurance carriers to offer a range of healthcare plans. 5 U.S.C. 8902, 8903. The Act directs that each contract between OPM and a carrier "shall contain a detailed statement of benefits offered," and "shall include such maximums, limitations, exclusions, and other definitions of benefits as [OPM] considers necessary or desirable." 5 U.S.C. 8902(d).

Federal employees may enroll in a carrier's plan under the terms of the contract between OPM and the carrier. 5 U.S.C. 8905(a). OPM issues official descrip-

tions of plan terms through a statement of benefits or plan brochure. 5 U.S.C. 8907. The government pays the bulk of the premiums, 5 U.S.C. 8906(b)(1), which are deposited into the Employee Health Benefits Fund in the U.S. Treasury, 5 U.S.C. 8909.

The Act contains an express-preemption provision. It provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. 8902(m)(1). Congress originally enacted the provision in 1978 "to establish uniformity in Federal employee health benefits and coverage." H.R. Rep. No. 282, 95th Cong., 1st Sess. 1 (1977) (1977 House Report); see Act of Sept. 17, 1978 (1978 Act), Pub. L. No. 95-368, 92 Stat. 606. Congress broadened it to its current form in 1998, to ensure that "national plans [can] offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 374, 105th Cong., 1st Sess. 9 (1997) (1997 House Report); see Federal Employees Health Care Protection Act of 1998 (1998 Act), Pub. L. No. 105-266, § 3(c), 112 Stat. 2366.

2. Petitioner is a FEHB insurance carrier that has entered into a contract with OPM to furnish health benefits. At all relevant times, Part II of petitioner's contract with OPM (titled "BENEFITS"), Pet. App. 122a, contained a section titled "SUBROGATION," *id.* at 129a-130a. "Subrogation" occurs when an insurer pays an insured for benefits, and then steps into the

insured's shoes to demand repayment from a third party who caused the loss. See *Black's Law Dictionary* 1654 (10th ed. 2014). "[S]ubrogation rights will commonly subsume reimbursement," which occurs when the insurer demands repayment from an insured who has recovered twice for the same injury, once from the insurer and again from a third party who caused the loss. *New Orleans Assets, L.L.C.* v. *Woodward*, 363 F.3d 372, 377 (5th Cir. 2004).

The subrogation clause in petitioner's contract with OPM stated, among other things, that petitioner "shall subrogate FEHB claims" in a State where "subrogation is prohibited," if petitioner also "subrogates for at least one plan covered under" the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.* Pet. App. 130a; see *FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990) (ERISA preempts state anti-subrogation laws).[1] It is undisputed that the subrogation clause required petitioner to "seek reimbursement or subrogation" in Missouri "when an insured obtains a settlement or judgment against a tortfeasor for payment of medical expenses." Pet. App. 45a. It is also undisputed that the term "subrogation" in the contract encompasses reimbursement. See Pet. 8; Resp. Br. 7.

3. OPM has issued detailed regulations governing subrogation and reimbursement clauses in FEHB contracts. 5 C.F.R. 890.106; see 80 Fed. Reg. at 29,203. Those regulations provide that a carrier's "right to pursue and receive subrogation and reimbursement recoveries *constitutes a condition of and a limitation on* the nature of benefits or benefit pay-

[1] The plan brochure stated, "[i]f you do not seek damages you must agree to let us try. This is called subrogation." Pet. App. 147a.

ments and on the provision of benefits under the plan's coverage." 5 C.F.R. 890.106(b)(1) (emphasis added). The regulations further provide:

> A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). *These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.*

5 C.F.R. 890.106(h) (emphasis added). This regulation "formalizes OPM's longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978," and it applies to "all FEHBA contracts." 80 Fed. Reg. at 29,204.[2]

OPM explained that these regulations "comport[] with longstanding Federal policy and further[] Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." 80 Fed. Reg. at 29,203. OPM noted that, in 2014, "FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries," "translat[ing] to premium cost savings for the federal government and FEHB enrollees." *Ibid.* OPM also stated that the regulations further "a strong federal interest in national uniformity" in coverage, benefits,

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[2] OPM's regulations also require carrier contracts entered into after June 22, 2015, to specify that benefits and benefits payments are extended "on the condition" that the carrier may pursue and receive subrogation and reimbursement. 5 C.F.R. 890.106(b)(2); see 80 Fed. Reg. at 29,203-29,204.

and administration. 80 Fed. Reg. at 932. Disuniformity, OPM explained, "is administratively burdensome, gives rise to uncertainty and litigation, and results in treating enrollees differently, although enrolled in the same plan and paying the same premium." *Ibid.* OPM further stated that "Congress enacted the preemption provision to avoid such disparities, and to enhance the ability of the Federal Government to offer its employees a program of health benefits governed by a uniform set of legal rules." *Ibid.*

4. a. Respondent is a former federal employee who enrolled in and was insured under petitioner's FEHB plan. Pet. App. 45a. He was injured in an automobile accident, and petitioner paid his medical expenses. *Ibid.* Respondent sued the driver who caused his injuries and recovered a monetary award in a settlement. *Ibid.* As contemplated by its contract with OPM, petitioner asserted a lien (for $6,592.24) against part of the settlement proceeds to cover medical bills petitioner had paid arising from the accident. *Ibid.* Respondent repaid that amount, satisfying the lien. *Ibid.*

Respondent then brought this class action suit against petitioner in Missouri state court, alleging that petitioner had improperly obtained reimbursement for medical benefits it paid. Pet. App. 45a. Respondents' state-law claims were "based on the premise that Missouri law does not permit the subrogation of tort claims." *Ibid.*; see *Benton House, LLC* v. *Cook & Younts Ins., Inc.*, 249 S.W.3d 878, 882 (Mo. Ct. App. 2008) ("[A]n insurer cannot seek subrogation from its insured."). In response, petitioner argued that Section 8902(m)(1) makes subrogation and reimbursement clauses in FEHB contracts effective notwithstanding state law. The state trial court granted

summary judgment for petitioner, Pet. App. 28a-32a, and the state court of appeals affirmed, *id.* at 33a-43a.

The Missouri Supreme Court reversed. Pet. App. 44a-54a. The court started "with the assumption that the historic police powers of the States [are] not to be superseded by . . . Federal Act unless that [is] the clear and manifest purpose of Congress." *Id.* at 47a (brackets in original) (quoting *Cipollone* v. *Liggett Grp., Inc.*, 505 U.S. 504, 516 (1992)). The court found Section 8902(m)(1) ambiguous as to whether subrogation and reimbursement were included within its preemptive scope. The court then concluded that it had "a duty to accept the reading that disfavors preemption." *Id.* at 49a (quoting *Bates* v. *Dow AgroSciences LLC*, 544 U.S. 431, 449 (2005)).

Judge Wilson concurred, joined by Judge Breckenridge. Pet. App. 55a-72a. He stated that "it defies logic to insist that benefit repayment terms do not *relate* to the nature or extent of [respondent's] benefits," and determined that "Congress plainly intended for § 8902(m)(1) to apply to the benefit repayment terms in [petitioner's] contract." *Id.* at 60a, 66a. Judge Wilson nonetheless concurred, reasoning that Congress cannot make the terms of FEHB contracts enforceable notwithstanding state law. *Id.* at 67a.

b. Petitioner filed a petition for a writ of certiorari, seeking this Court's review of the Missouri Supreme Court's decision. The Court invited the Solicitor General to file a brief expressing the views of the United States. 135 S. Ct. 323. While the petition was pending, OPM promulgated its regulations governing subrogation and reimbursement. See pp. 4-6, *supra*. This Court granted certiorari, vacated the Missouri Supreme

Court's decision, and remanded for further consideration in light of the new regulations. Pet. App. 73a.

c. On remand, the Missouri Supreme Court reaffirmed its prior ruling. Pet. App. 1a-13a. The court stated that the "OPM regulation does not overcome the presumption against preemption and demonstrate Congress' clear and manifest intent to preempt state law." *Id.* at 2a. But see *Bell* v. *Blue Cross & Blue Shield*, 823 F.3d 1198 (8th Cir. 2016) (finding state anti-subrogation law preempted), petition for cert. pending, No. 16-504 (filed Oct. 11, 2016); *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090 (10th Cir. 2015) (same); *Kobold* v. *Aetna Life Ins. Co.*, 370 P.3d 128 (Ariz. Ct. App. 2016) (same).

Judge Wilson concurred, joined by a majority of the judges of the Missouri Supreme Court. Pet. App. 14a; *id.* at 13a (identifying judges). In the concurring judges' view, Congress's "attempt to give preemptive effect to the provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause" and, "therefore, does not displace Missouri law here." *Id.* at 14a.

SUMMARY OF ARGUMENT

I. Subrogation and reimbursement clauses in FEHB contracts are effective notwithstanding state anti-subrogation laws because Congress has shielded FEHB contracts from state interference, 5 U.S.C. 8902(m)(1), and subrogation and reimbursement clauses fall within the scope of that protective umbrella.

OPM has recently promulgated regulations codifying its longstanding interpretation of the FEHB Act to have that effect. 5 C.F.R. 890.106(b)(1) and (h). That interpretation bars Missouri from prohibiting subrogation that a FEHB contract requires. *Ibid.*

Those regulations embody by far the best interpretation of the statute. At a minimum, they reasonably resolve any ambiguity and are therefore binding under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council*, 467 U.S. 837 (1984).

A subrogation or reimbursement clause "relate[s] to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits)," 5 U.S.C. 8902(m)(1), because such a clause imposes a "condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage." 5 C.F.R. 890.106(b)(1). When subrogation is triggered, a carrier's payments to a beneficiary must be paid back. Moreover, Congress has assigned to OPM the power to decide what "limitations * * * and other definitions of benefits" a carrier contract "shall contain." 5 U.S.C. 8902(d). OPM has reasonably concluded that subrogation is such a "limitation" on benefits, 5 C.F.R. 890.106(b)(1), and therefore relates to the nature, provision, and extent of benefits and benefit payments under the FEHB Act's preemption provision, 5 U.S.C. 8902(m)(1). See 5 C.F.R. 890.106(h).

OPM's common-sense interpretation furthers Section 8902(m)(1)'s purposes. Congress enacted that provision to ensure that uniform, national rules will govern the administration of benefits for federal workers—and to prevent individual States from undermining the federal government's cost-cutting efforts or creating unfair disparities between similarly situated federal employees. If individual States could prohibit FEHB subrogation, the federal government would spend more money to insure federal employees, and federal employees who pay the same premiums

under the same plan would receive different benefits: Federal employees in anti-subrogation States would get to keep payments, whereas those in other States would have to pay them back. Out-of-state enrollees in the plan who cannot receive the advantages of an anti-subrogation law (the ability to keep benefit payments) would nonetheless suffer their disadvantage (the increased premiums needed to pay for those unreturned benefits)—and would cross-subsidize the expanded benefits received solely by in-state workers.

The Missouri Supreme Court disagreed, reasoning that a "presumption against preemption" applied and effectively trumped *Chevron*, leaving OPM powerless to interpret Section 8902(m)(1). Pet. App. 2a. That is wrong for three reasons, each of which independently warrants reversal. And collectively, they make it even clearer that the decision below is wrong.

First, this Court has repeatedly applied *Chevron* deference to regulations interpreting the substantive scope of a statutory provision that preempts state law. *E.g.*, *Cuomo* v. *Clearing House Ass'n*, 557 U.S. 519, 525 (2009); *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735, 743-744 (1996) (rejecting an argument that the presumption against pre-emption "in effect trumps *Chevron*"). A "general conferral of rulemaking authority * * * validate[s] rules for *all* the matters the agency is charged with administering." *City of Arlington* v. *FCC*, 133 S. Ct. 1863, 1874 (2013). And the case for deference is particularly strong here because Congress has charged OPM with determining what "limitations" to impose and what "other definitions of benefits" to prescribe in its carrier contracts. 5 U.S.C. 8902(d). *Chevron* therefore applies to OPM's

interpretation of both Section 8902(m)(1) itself and the substantive terms in that provision.

Second, even without OPM's regulations, it would be improper to "presume" that Congress intended to preserve a role for state law under the FEHB program, because Congress enacted Section 8902(m)(1) to *prevent* state regulation that might interfere with its implementation. When a "statute 'contains an express pre-emption clause,'" the Court does "not invoke any presumption against pre-emption." *Puerto Rico* v. *Franklin Cal. Tax-Free Trust*, 136 S. Ct. 1938, 1946 (2016) (quoting *Chamber of Commerce of the U.S.* v. *Whiting*, 563 U.S. 582, 594 (2011)).

Third, even overlooking *both* OPM's regulations *and* the express-preemption provision, a presumption against preemption would not apply: There is no basis for "presuming" that Congress wanted to allow States to regulate benefits under "a *federal* health insurance plan for *federal* employees that arise from a *federal* law." *Bell* v. *Blue Cross & Blue Shield*, 823 F.3d 1198, 1202 (8th Cir. 2016) (emphases added), petition for cert. pending, No. 16-504 (filed Oct. 11, 2016). "[A]n 'assumption' of nonpre-emption is not triggered when [a] State regulates in an area where there has been a history of significant federal presence." *United States* v. *Locke*, 529 U.S. 89, 108 (2000). And "[i]t is an understatement to say that 'there has been a history of significant federal presence' in the area of federal employment." *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1105 (10th Cir. 2015).

II. The Act's express-preemption provision is constitutional. Although it is "unusual" for a statute to provide that the terms of a federal contract preempt state law, *Empire Healthchoice Assurance, Inc.* v.

McVeigh, 547 U.S. 677, 697 (2006), that creates no constitutional problem. Section 8902(m)(1) itself does the preempting here, with the reference to contract terms establishing the scope of the preemption. Section 8901(m)(1) thus creates a protective umbrella under which OPM can enter into contracts with carriers to provide uniform, nationwide coverage, sheltered from state interference. Congress plainly has the authority to create such a protected zone, and it has done so many times.

Indeed, this case involves an area of "uniquely federal interest" where uniform federal common law would apply—even without an express-preemption provision—when there is a "significant conflict" between state law and federal interests. *McVeigh*, 547 U.S. at 692-693 (quoting *Boyle* v. *United Techs. Corp.*, 487 U.S. 500, 507 (1988)). It follows *a fortiori* from *McVeigh* and *Boyle* that Congress can enact a statute declaring that uniform federal law will govern the terms and enforcement of FEHB contracts.

ARGUMENT

I. Section 8902(m)(1) Requires That Subrogation And Reimbursement Clauses In FEHB Contracts Be Given Effect Notwithstanding State Anti-Subrogation Laws

A. OPM's Regulations Embody By Far The Best Interpretation Of Section 8902(m)(1)

1. a. Congress has granted OPM authority to determine what health "benefits" a carrier will offer in a contract, and to include in the contract such "limitations" and "other definitions of benefits as [it] considers necessary or desirable." 5 U.S.C. 8902(d). And Congress has further provided that contract terms that "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to

benefits) *shall supersede and preempt any State or local law* * * * which relates to health insurance or plans." 5 U.S.C. 8902(m)(1) (emphasis added). It is undisputed that Missouri's law prohibiting health-insurance subrogation "relates to health insurance or plans." *Ibid.* Accordingly, the only questions are (1) what is included in the "nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" available under a FEHB contract; and (2) whether a subrogation clause "relate[s] to" the nature, provision, or extent of those benefits or benefit payments. *Ibid.*

OPM's regulations answer both questions. They provide that a carrier's "right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage." 5 C.F.R. 890.106(b)(1).[3] OPM's regulations further provide that "[a] carrier's rights and responsibilities pertaining to subrogation and reimbursement" under a FEHB contract "relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits)" within the meaning of Section 8902(m)(1), and "*are therefore effective notwithstanding any state or local law*" relating to health insurance or plans. 5 C.F.R. 890.106(h) (emphasis added). Petitioner therefore may obtain subrogation according to the terms of its contract with OPM, notwithstanding Missouri law.

b. In *Empire Healthchoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006), this Court addressed

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[3] Contracts now must specify that benefits and benefits payments are extended "on the condition" that the carrier may pursue and receive subrogation and reimbursement. 5 C.F.R. 890.106(b)(2).

whether a FEHB carrier's action for subrogation and reimbursement arose under federal law, and thus could be bought in federal court under 28 U.S.C. 1331. In concluding that such an action did not arise under federal law, the Court described Section 8902(m)(1) as a "puzzling measure" that was "open to more than one construction"—including the interpretation OPM has adopted. *McVeigh*, 547 U.S. at 697-698. The Court explained that a "reimbursement clause" in a contract between OPM and a carrier could be interpreted as a "condition or limitation on 'benefits' received by a federal employee," and thus as a contract term "'relat-[ing] to . . . coverage or benefits' and 'payments with respect to benefits.'" *Id.* at 697 (brackets in original). On the other hand, the Court noted, Section 8902(m)(1) could be read to refer to a beneficiary's initial entitlement to benefits, not a carrier's entitlement to obtain reimbursement later. *Ibid.*

The Court did not definitively interpret Section 8902(m)(1) in *McVeigh*, however, because it would not be a basis for federal jurisdiction on either interpretation. 547 U.S. at 697. Section 8902(m)(1) is a "choice-of-law prescription," the Court concluded, not a "jurisdiction-conferring provision." *Ibid.*

McVeigh therefore left OPM with authority to adopt regulations definitively resolving the textual ambiguity the Court found as to whether subrogation and reimbursement clauses fit within Section 8902(m)(1)'s terms. See *National Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 982 (2005). OPM has now exercised that authority, issuing regulations providing that a carrier's "right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the na-

ture of benefits or benefit payments and on the provision of benefits under the plan's coverage." 5 C.F.R. 890.106(b)(1); see 5 C.F.R. 890.106(h) (such terms are "effective notwithstanding any state or local law").

c. OPM's interpretation is the most natural reading of the statutory language. A subrogation or reimbursement clause is a "limitation[]" that serves to "defin[e]" the "benefits" that a plan offers, 5 U.S.C. 8902(d), by imposing a "condition of and a limitation on" those benefits and benefit payments, and thus on the provision of those benefits, 5 C.F.R. 890.106(b)(1). It does so by making benefits and benefit payments contingent rather than final: When subrogation is triggered, the benefits paid by the carrier must be paid back. The common sense of this understanding is confirmed by the Medicare secondary-payer statute, which provides that Medicare payments are "conditioned on reimbursement" and must be repaid if the recipient later receives payment from another plan. 42 U.S.C. 1395y(b)(2)(B) ("Conditional Payment").

Subrogation and reimbursement clauses in turn "relate to" the "nature, provision, or extent" of those benefits and benefit payments for purposes of Section 8902(m)(1). The ordinary meaning of the phrase "relate to" "is a broad one," meaning "to stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with." *Morales* v. *Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992) (quoting *Black's Law Dictionary* 1158 (5th ed. 1979)); see *Northwest, Inc.* v. *Ginsberg*, 134 S. Ct. 1422, 1428, 1430-1431 (2014) (the phrase "related to" in an express-preemption provision "expresses a 'broad pre-emptive purpose'"). As set forth above, subrogation and reimbursement clauses "limit[]" and

"defin[e]" the benefits that are provided in the first place. 5 U.S.C 8902(d). Such a clause imposes a "limitation" on benefits and any payments with respect to those benefits, *ibid.*, making them conditional in "nature" rather than final: When subrogation is triggered, benefits paid by a carrier must be paid back. And they also define the "extent" of benefits and payments with respect to benefits, because they define the extent of the payments the insured can keep. Subrogation clauses therefore relate to the "nature, provision, or extent" of the "benefits" themselves, as well as to the "nature, provision, or extent" of "payments with respect to benefits." 5 U.S.C. 8902(m)(1).

That conclusion is consistent with this Court's cases. This Court has held that a state "antisubrogation law 'relate[s] to' an employee benefit plan," within the meaning of ERISA's preemption clause. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990) (brackets in original). There is no basis for concluding that Congress intended a broader role for state law—and thus less uniformity—in regulating the *federal government's* relationship with *federal* employees than in regulating private retirement plans under ERISA. The fact that a payment may need to be refunded is closely "connected to" and "associated with" the nature and extent of both the benefits themselves and any payment of benefits that was made in the first place.

It is thus no surprise that the courts of appeals that have considered OPM's regulations have likewise concluded that they set forth the best reading of the statute. See *Bell* v. *Blue Cross & Blue Shield*, 823 F.3d 1198, 1203 (8th Cir. 2016) ("[T]he better reading of the statute" is that "reimbursement and subrogation provisions are limitations on the payment of bene-

fits."), petition for cert. pending, No. 16-504 (filed Oct. 11, 2016); *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1106 (10th Cir. 2015) ("[T]he best construction of the preemption provision * * * strongly support[s] Blue Cross" because "an enrollee's ultimate entitlement to benefit payments is conditioned upon providing reimbursement from any later recovery or permitting the Plan to recover on the enrollee's behalf"); see also *Kobold* v. *Aetna Life Ins. Co.*, 370 P.3d 128, 132 (Ariz. Ct. App. 2016) ("The connection between issuing benefit payments and seeking subrogation and reimbursement is not so attenuated as to make the regulations' interpretation unreasonable."). And in his original concurring opinion below, Judge Wilson stated that it "defies logic to insist that benefit repayment terms do not *relate* to the nature or extent of [respondent's] benefits": "[T]erms requiring [him] to *pay* benefits back to [petitioner] that [petitioner] previously had *paid* out are terms that relate to 'payment with respect to [his] benefits.'" Pet. App. 60a-61a.

2. The interpretation embodied in OPM's regulations also directly furthers Section 8902(m)(1)'s purposes of "promot[ing] uniformity in the administration of federal employee benefits and stewardship of the public fisc." *Bell*, 823 F.3d at 1204.

a. Congress enacted Section 8902(m)(1) in response to state laws "requiring not only specific types of care but the extent of benefits, family members to be covered, the age limits for family members, extension of coverage, [and] the format and the type of informational material that must be furnished, including in some instances the type of language to be used." 1977 House Report 6-7. Congress was concerned that

such "mandated benefit" laws would result in "[i]ncreased premium costs to both the Government and enrollees," as well as "[a] lack of uniformity of ben[e]fits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States." H.R. Rep. No. 1211, 94th Cong., 2d Sess. 3 (1976); see S. Rep. No. 903, 95th Cong., 2d Sess. 7 (1978) ("These laws in effect presented serious problems from the standpoint of the uniformity of benefits under the program."). Congress accordingly provided in 1978 that FEHB contract terms that "relate to the nature or extent of coverage or benefits (including payments with respect to benefits)" preempt any state law relating to health insurance or plans, "to the extent that such law or regulation is inconsistent with such contractual provisions." 1978 Act, 92 Stat. 606.

Congress later expanded the preemption provision. See 1998 Act § 3(c), 112 Stat. 2366. First, Congress expanded it to preempt state laws without regard to whether they are "inconsistent" with FEHB contracts terms, "thereby giving the federal contract provisions clear authority." S. Rep. No. 257, 105th Cong., 2d Sess. 15 (1998) (1998 Senate Report). Second, Congress expanded it to reach terms relating to the "provision" of coverage or benefits. 5 U.S.C. 8902(m)(1). Congress thereby "strengthen[ed] the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and "prevent[ed] carriers' cost-cutting initiatives from being frustrated by State laws." 1997 House Report 9; see *McVeigh*, 547 U.S. at 686 (describing this history).

b. OPM's interpretation of Section 8902(m)(1) advances Congress's goals of "reducing health care costs and enabling uniform, nationwide application of FEHB contracts," by ensuring that subrogation and reimbursement clauses are uniformly enforceable and effective regardless of where the federal employee resides. 80 Fed. Reg. at 29,203.

"The FEHB program insures approximately 8.2 million federal employees, annuitants, and their families, a significant proportion of whom are covered through nationwide fee-for-service plans with uniform rates." 80 Fed. Reg. at 29,203. OPM estimated that "FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries" in 2014. *Ibid.* Accordingly, "[s]ubrogation recoveries translate to premium cost savings for the federal government and FEHB enrollees." *Ibid.*

OPM's regulations similarly further Congress's purpose of promoting national uniformity in coverage, benefits, and administration. 80 Fed. Reg. at 932; cf. *Holliday*, 498 U.S. at 60 ("Application of differing state subrogation laws to [ERISA] plans would * * * frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide."). Disuniformity "is administratively burdensome, gives rise to uncertainty and litigation, and results in treating enrollees differently, although enrolled in the same plan and paying the same premium." 80 Fed. Reg. at 932. Federal employees "in states without [anti-subrogation] laws would have to pay reimbursements that are then used to benefit enrollees throughout the country, even those who live in states where they could keep their tort recoveries without paying reimbursements." *Helfrich*, 804 F.3d at 1099. Depending

on where they lived, federal employees insured under the same plan and paying the same premiums would obtain different benefits under different conditions and limitations, and would be able to keep different payment amounts. The disuniformity here thus would result in unfairness and real-world financial harm to federal employees.

"Congress enacted the preemption provision to avoid such disparities, and to enhance the ability of the Federal Government to offer its employees a program of health benefits governed by a uniform set of legal rules." 80 Fed. Reg. at 932; see *Helfrich*, 804 F.3d at 1099. Indeed, Missouri's anti-subrogation rule is indistinguishable in this respect from the state mandated-benefit laws that Congress enacted the preemption provision to target: Those laws created the same kind of disuniformity, increased costs, and unfair cross-subsidization. See pp. 17-18, *supra*.

B. OPM's Regulations Are Authoritative

At the very least, OPM's regulations reasonably interpret the relevant provisions of the FEHB Act, and are therefore controlling under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council*, 467 U.S. 837, 843-844 (1984). Indeed, no court has held that OPM's interpretation is unreasonable. See Pet. App. 3a (describing it as "plausible"); Resp. Mo. Sup. Ct. Br. 31, 36 (same). OPM issued its regulations pursuant to express authority to issue regulations to carry out the Act, 5 U.S.C. 8913(a), which includes not only the preemption provision, 5 U.S.C. 8902(m)(1), but also the grant of authority to prescribe the "benefits offered" as well as the "limitations" and "other definitions of benefits as [it] considers necessary or desirable," 5 U.S.C. 8902(d). This Court has held that,

where Congress has granted an agency authority to prescribe definitions of terms in a statute, the agency's rules exercising that authority are entitled to heightened deference. See *Chevron*, 467 U.S. at 843-844 & n.12 (citing, *inter alia*, *Batterton* v. *Francis*, 432 U.S. 416, 424-426 (1977)).

The Missouri Supreme Court nonetheless "decline[d]" to provide *any* deference to OPM's regulations, on the theory that *Chevron* deference does not apply to regulations interpreting an express-preemption provision. Pet. App. 5a. The court then relied on a "presumption against preemption" to definitively foreclose OPM's interpretation. *Id.* at 2a; see *id.* at 3a ("[T]he 'historic police powers of the States' are generally preempted only when the federal statute at issue indicates that preemption is the 'clear and manifest purpose of Congress.'") (quoting *Cipollone* v. *Liggett Grp., Inc.*, 505 U.S. 504, 516 (1992)).

That approach is fundamentally misguided and conflicts with this Court's holdings that (1) *Chevron* applies to regulations interpreting substantive terms in statutory provisions that have preemptive effect; (2) a "presumption against preemption" does not apply to when interpreting an express-preemption provision; and (3) a "presumption against preemption" does not in any event apply in an area like this, with a history of significant federal presence. Each of those errors independently warrants reversal. Collectively, they make the decision below clearly wrong.

1. This Court recently rejected an argument, similar to the one the Missouri Supreme Court adopted below, that *Chevron* applies to some parts of a statute an agency is charged with administering, but not to others. Rather, a "general conferral of rulemaking

authority * * * validate[s] rules for *all* the matters the agency is charged with administering." *City of Arlington* v. *FCC*, 133 S. Ct. 1863, 1874 (2013). "[T]he whole includes all of its parts." *Ibid.* Indeed, in *City of Arlington*, the Court specifically noted that it had deferred to an agency "assertion that its broad regulatory authority extends to preempting conflicting state rules." *Id.* at 1871 (citing *City of New York* v. *FCC*, 486 U.S. 57, 64 (1988), and *Capital Cities Cable, Inc.* v. *Crisp*, 467 U.S. 691, 700 (1984)).

Chevron accordingly applies here. OPM's rulemaking authority under Section 8913(a) encompasses all of the Act's parts—including its preemption provision, 5 U.S.C. 8902(m)(1), as well as its grant of authority to OPM to determine what benefits to offer and what "limitations" and "other definitions of benefits" to impose, 5 U.S.C. 8902(d). And OPM's authority under the latter provision necessarily encompasses authority to flesh out the substantive terms that appear in the preemption provision, namely, "the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. 8902(m)(1).

This Court has consistently relied on *Chevron* when analyzing regulations that interpret the substantive scope of federal statutes that preempt state law. See *Cuomo* v. *Clearing House Ass'n*, 557 U.S. 519, 525 (2009); *New York* v. *FERC*, 535 U.S. 1, 28 (2002); *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 496 (1996); *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735, 739-744 (1996). For example, in *Smiley*, the Court applied *Chevron* to defer to a regulation interpreting the term "interest" in 12 U.S.C. 85, a provision that the Court had previously held was preemptive. *Smiley*, 517 U.S. at 737-745. The Court declined to decide whether *Chevron*

would apply to "the question of *whether* a statute is pre-emptive." *Id.* at 744. But the Court explained that that was "*not* the question at issue," because "there [wa]s no doubt that § 85 pre-empts state law." *Ibid.* Rather, the only question in the case was "the substantive (as opposed to pre-emptive) *meaning* of a statute," namely, the meaning of "interest." *Ibid.* The Court applied *Chevron* deference to the agency's interpretation of that term: The "regulation deserves deference," the Court stated, and was "obviously" reasonable. *Id.* at 745. And "the presumption against . . . pre-emption," the Court explained, does not "trump[] *Chevron*." *Id.* at 744 (citation omitted).

Similarly, in *Lohr*, the Court relied on *Chevron* to give "substantial weight" to the Food and Drug Administration's interpretation of what constitutes a "requirement" within the meaning of the express-preemption provision of the Medical Device Amendments of 1976, 21 U.S.C. 360k. *Lohr*, 518 U.S. at 496. And in *Clearing House*, the Court unanimously agreed that the *Chevron* framework applied to a regulation interpreting the phrase "visitorial powers" in an express-preemption provision, 12 U.S.C. 484(a), concluding that the agency could "give authoritative meaning to the statute within the bounds of [the] uncertainty" as to that phrase's meaning. *Clearing House*, 557 U.S. at 525; see *id.* at 538 (Thomas, J., concurring in part and dissenting in part) (the regulation "falls within the heartland of *Chevron*"). The Court ultimately held that the agency had stretched the statute beyond its "outer limits." *Id.* at 525. But *Chevron* defined where those "outer limits" were placed: The question was whether the regulation

could "be upheld as a *reasonable* interpretation of the National Bank Act." *Id.* at 523-524 (emphasis added).

OPM's regulations warrant deference here for the same reasons. As in *Smiley*, *Lohr*, and *Clearing House*, there is no doubt that the statutory provision at issue (Section 8902(m)(1)) triggers preemption. The only question is a substantive question about its scope: whether a subrogation clause "relate[s] to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. 8902(m)(1). OPM's conclusion that subrogation rights impose a "condition of and a limitation on" benefits and benefit payments, and therefore relate to the nature, provision, and extent of benefits or benefit payments, 5 C.F.R. 890.106(b)(1) and (h), is embodied in "a full-dress regulation" that was "adopted pursuant to the notice-and-comment procedures of the Administrative Procedure Act." *Smiley*, 517 U.S. at 741. OPM's interpretation also lies at the heart of the agency's responsibilities and expertise under the FEHB Act. OPM's regulations therefore are "authoritative." *Clearing House*, 557 U.S. at 525.[4]

2. Even without OPM's regulations, it would be incorrect to "presume" that Congress wanted to permit state regulation of subrogation and reimbursement required under FEHB contracts and OPM regulations, because Congress enacted Section 8902(m)(1) for the very purpose of preventing state interference

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[4] At a minimum, OPM's "experience[d] and informed judgment" is entitled to a "measure of respect" sufficient to uphold its interpretation. *Federal Express Corp.* v. *Holowecki*, 552 U.S. 389, 399 (2008) (quoting *Skidmore* v. *Swift*, 323 U.S. 134, 140 (1944)). See *Helfrich*, 804 F.3d at 1109-1110 (adopting OPM's interpretation under *Skidmore* without deciding whether *Chevron* would apply).

with OPM's administration of this national program. When a "statute 'contains an express pre-emption clause,'" the Court does "not invoke any presumption against pre-emption but instead 'focus[es] on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent.'" *Puerto Rico* v. *Franklin Cal. Tax-Free Trust*, 136 S. Ct. 1938, 1946 (2016) (quoting *Chamber of Commerce of the U.S.* v. *Whiting*, 563 U.S. 582, 594 (2011)); see *Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016) (ERISA "certainly contemplated the pre-emption of substantial areas of traditional state regulation.") (citation omitted).

The one-two punch of giving no deference to OPM's interpretation of Section 8902(m)(1) and its substantive terms, coupled with applying a "presumption against preemption" to narrow Section 8902(m)(1), is particularly problematic. That approach would render the expert federal agency powerless to interpret the scope of a statutory provision that could have a significant effect on its ability to implement, on a nationwide basis, the program Congress has charged it with administering. Congress used broad phrasing in Section 8902(m)(1) precisely to give broad protection for OPM and carriers against state interference in prescribing, implementing, and enforcing contract terms. But because Section 8902(m)(1) paints with a broad brush, it may be ambiguous whether a particular kind of contract provision falls within its aegis. Application of a "presumption against preemption" that trumps *Chevron* thus would be a one-way ratchet, leading to more and more cramped interpretations of Section 8902(m)(1)—and thus permitting more and more of the state interference Congress enacted it to prevent.

3. Even ignoring both OPM's regulations and Section 8902(m)(1), there would be no "presumption" favoring state regulation here, because "this dispute concerns benefits from a *federal* health insurance plan for *federal* employees that arise from a *federal* law." *Bell*, 823 F.3d at 1201-1202 (emphases added). "[A]n 'assumption' of nonpre-emption is not triggered when the State regulates in an area where there has been a history of significant federal presence." *United States* v. *Locke*, 529 U.S. 89, 108 (2000). For example, in *Buckman Co.* v. *Plaintiffs' Legal Committee*, 531 U.S. 341 (2001), this Court held that no presumption against preemption applied when a State sought to impose common-law fraud duties upon "the relationship between a federal agency and the entity it regulates." *Id.* at 347. That relationship "is inherently federal," the Court explained, because it "originates from, is governed by, and terminates according to federal law." *Ibid.*; see *Locke*, 529 U.S. at 108 (declining to apply a presumption against preemption of state regulations touching upon "national and international maritime commerce").

"It is an understatement to say that 'there has been a history of significant federal presence' in the area of federal employment." *Helfrich*, 804 F.3d at 1105 (citation omitted). "Congress has legislated on the matter from the outset." *Ibid.* And, as in *Buckman*, the relationship among the federal government, an insurance carrier that has contracted with the federal government to furnish health benefits to federal employees, and those employees, "is inherently federal" because it "originates from, is governed by, and terminates according to federal law." 531 U.S. at 347.

As a result, application of a presumption against preemption is exactly backwards: "The conflict with federal policy *need not be as sharp* as that which must exist for ordinary preemption when Congress legislates 'in a field which the States have traditionally occupied.'" *Boyle* v. *United Techs. Corp.*, 487 U.S. 500, 507 (1988) (emphasis added) (quoting *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). Preemption is thus more likely here, not less.

Accordingly, there can be no "presumption" in favor of allowing States to regulate the terms upon which the federal government provides benefits to federal workers pursuant to a federal contract entered into under a federal statute. Congress enacted the express-preemption provision precisely to confirm that OPM can administer FEHB plans free from state interference. And "there is hardly an area in which a state would have less of a legitimate interest than this employment relationship." *Helfrich*, 804 F.3d at 1100.

II. Congress Has Ample Constitutional Authority To Shield FEHB Contracts From State Interference

Section 8902(m)(1)'s wording is "unusual" because it states that "[t]he terms" of a federal contract "shall supersede and preempt" state law. *McVeigh*, 547 U.S. at 697; 5 U.S.C. 8902(m)(1). But that language is not unique, 5 U.S.C. 8959, 8989, 9005(a); see 10 U.S.C. 1103(a); 49 U.S.C. 10709(b), and it does not create any constitutional problem.

1. Section 8902(m)(1) is properly understood to do the preempting itself, with the reference to contract terms defining the scope of the preemption. Section 8902(m)(1) thereby provides a protective umbrella under which OPM can contract with carriers on a uniform national basis, without interference by a

patchwork of state and local law. So long as FEHB contract terms "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)," Section 8902(m)(1) ensures that those terms will be uniformly enforceable nationwide, notwithstanding any state law relating to "health insurance or plans." 5 U.S.C. 8902(m)(1). And an easy, shorthand way of ensuring that an agency's contracts will be governed by uniform federal law is to enact a statute declaring that the agency's contracts "shall supersede and preempt" state law. *Ibid.* But it is still the statute, not the contract itself, that does the preempting.

Section 8902(m)(1) is reasonably interpreted in this uncontroversial manner, which is faithful to Congress's purpose. See *Bell*, 823 F.3d at 1204 ("[T]he statute can reasonably be construed to mean that federal law," not "the contractual terms, has the preemptive force."); *Empire Healthchoice Assurance, Inc.* v. *McVeigh*, 396 F.3d 136, 144-145 (2d Cir. 2005) (Sotomayor, J.) (similar), aff'd 547 U.S. 677 (2006); OPM, *FEHB Program Carrier Letter No. 2012-18*, at 1 (June 18, 2012) ("[FEHBA] preempts state laws prohibiting or limiting subrogation and reimbursement") (Pet. App. 116a).

This interpretation eliminates any conceivable constitutional doubt. Section 8902(m)(1) is a "Law[] of the United States" within the meaning of the Supremacy Clause. U.S. Const. Art. VI, Cl. 2. And "[i]t is the very essence of supremacy * * * to modify every power vested in subordinate governments, as to exempt its own operations from their own influence." *McCulloch* v. *Maryland*, 17 U.S. (4 Wheat.) 316, 427 (1819). Indeed, the Constitution itself provides simi-

lar protection from state interference in some contexts. *Ibid.*; *e.g.*, *United States* v. *New Mexico*, 455 U.S. 720, 735 (1982) (private parties may be constitutionally immune from state taxation when acting pursuant to a federal contract); *Arizona* v. *California*, 283 U.S. 423, 451 (1931) ("The United States may perform its functions without conforming to the police regulations of a state."); *Helfrich*, 804 F.3d at 1100 n.7 (collecting cases). Federal common law does as well. *E.g.*, *Boyle*, 487 U.S. at 504 ("[O]bligations to and rights of the United States under its contracts are governed exclusively by federal law.").

Congress has enacted many laws providing a protective umbrella for both private and public action, similar to that afforded by Section 8902(m)(1). This Court recently and unanimously found preemption under the Federal Employees' Group Life Insurance Act of 1954, 5 U.S.C. 8709(d)(1), which provides that "[t]he provisions of any contract" under that Act "shall supersede and preempt" state law. *Ibid.*; see *Hillman* v. *Maretta*, 133 S. Ct. 1943, 1948 (2013). Under the "filed rate doctrine," Congress has enabled sellers of electricity and natural gas to set rates (and the government to approve those rates), without state interference. See *Entergy La., Inc.* v. *Louisiana Pub. Serv. Comm'n*, 539 U.S. 39, 47 (2003); *Arkansas La. Gas Co.* v. *Hall*, 453 U.S. 571, 578-579 (1981). The Federal Aviation Administration Authorization Act of 1994, 49 U.S.C. 14501(c)(1) and 41713(b)(4)(A), enables private air and motor carriers to establish rates, routes, and services, without state interference. See *Rowe* v. *New Hampshire Motor Transp. Ass'n*, 552 U.S. 364 (2008). ERISA enables private parties to form employee benefit plans, protected from state

inference. 29 U.S.C. 1144(a); see *Gobeille*, 136 S. Ct. at 942-947. And the Federal Arbitration Act, 9 U.S.C. 2, enables private parties to agree to arbitration, protected from state interference. See *Preston* v. *Ferrer*, 552 U.S. 346, 349-350 (2008).

Section 8902(m)(1) does essentially the same thing for OPM and the carriers that provide federal benefits to federal employees. Indeed, if the federal government itself did all the carriers' work in-house, there would be no question that its subrogation efforts would be immune from state interference. Congress is not disabled from providing the same protection from state interference when it chooses to furnish the same benefits through contracts with private carriers.

2. In any event, Congress has the power to declare that the terms of a FEHB contract themselves preempt state law. Even absent "a clear statutory prescription," the terms of a federal contract can displace state law. *Boyle*, 487 U.S. at 504. In *Boyle*, the Court held that design specifications in a federal procurement contract for a military helicopter preempted a state-law tort suit against the contractor alleging that the design was defective. The Court explained that "obligations to and rights of the United States under its contracts are governed exclusively by federal law." *Ibid.*; see *Clearfield Trust Co.* v. *United States*, 318 U.S. 363, 366-367 (1943). And although the dispute in *Boyle* was "between private parties," the Court found it "plain that the Federal Government's interest in the procurement of equipment is implicated by suits such as the present one." 487 U.S. at 506.

This Court recognized in *McVeigh* that, under *Boyle*, federal common law would govern the terms of a FEHB contract—and thus that the contract terms

would preempt state law—if a "significant conflict" were demonstrated "between an identifiable federal policy or interest and the operation of state law." 547 U.S. at 692-693 (quoting *Boyle*, 487 U.S. at 507); cf. *McVeigh*, 396 F.3d at 142 ("We recognize the possibility that at a later stage in the proceedings, a significant conflict might arise between New York state law and the federal interests underlying FEHBA.").

OPM's regulations embody its expert determination that a significant conflict exists. See 80 Fed. Reg. at 932 (application of state anti-subrogation laws to FEHB contracts conflicts with "major goals of Congress" in cost-savings and uniformity); cf. *Boyle*, 497 U.S. at 511 (relying on a federal statute as evidence of a "significant conflict"). Indeed, "[t]he conflict between the state regulation and the federal contractual requirement" here "is a stark one, starker than in *Boyle*." *Helfrich*, 804 F.3d at 1099. "In *Boyle*, the prospect of tort liability could deter a contractor from doing the government's bidding or cause it to raise the contract price. Here, state law outright forbids [the carrier] from fulfilling its contractual obligation" to subrogate. *Ibid.*

Congress enacted and expanded Section 8902(m)(1) to ensure that OPM could implement the FEHB program free from state interference by providing that the contract terms supersede state law, without any need to demonstrate an inconsistency on a case-by-case basis. See pp. 17-18, *supra*. It follows *a fortiori* from *McVeigh* and *Boyle* that Section 8920(m)(1) is constitutional: Congress has the constitutional authority to clarify and confirm that uniform federal law governs FEHB contract terms, when uniform federal law might govern those same terms even without a

statute. "[F]ederal programs that 'by their nature are and must be uniform in character throughout the Nation' necessitate formulation of controlling federal rules." *United States* v. *Kimbell Foods, Inc.*, 440 U.S. 715, 728 (1979) (quoting *United States* v. *Yazell*, 382 U.S. 341, 354 (1966)). There is no basis for concluding that federal courts have the authority to determine that "controlling federal rules" of a uniform nature must apply in this context, *ibid.*, but that Congress cannot make that same determination itself to "giv[e] the federal contract provisions clear authority." 1998 Senate Report 15.

CONCLUSION

The judgment of the Supreme Court of Missouri should be reversed.

Respectfully submitted.

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In the Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,
fka Group Health Plan, Inc.,
Petitioner,

v.

JODIE NEVILS,
Respondent.

On Writ of Certiorari to the Supreme Court of Missouri

BRIEF OF THE AMERICAN ASSOCIATION FOR JUSTICE AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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IDENTITY AND INTEREST OF AMICUS CURIAE

The American Association for Justice ("AAJ") is a voluntary national bar association whose members primarily represent plaintiffs in personal injury actions, employment rights cases, consumer cases and other civil actions which seek to vindicate the rights of individuals under both federal statutory law and state tort law.

AAJ is concerned that the OPM rule at issue in this case undermines both the important policies underlying state tort law and Congress's purpose in providing insurance for federal workers.[1]

SUMMARY OF ARGUMENT

1. One of the cornerstones of this Court's preemption jurisprudence is the principle that a federal statute does not supersede state law unless Congress has stated its intent to do so clearly and unambiguously. When an express preemption provision is susceptible of more than one plausible interpretation, the Court accepts the reading that disfavors preemption. The assertion that the Court's reliance on this presumption has waned is incorrect. This Court has consistently applied this principle in express preemption cases. Where the text of the statute is plain, there is no need

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[1] The parties have consented to the filing of this brief. The undersigned counsel for amicus curiae affirms, pursuant to Supreme Court Rule 37.6, that no counsel for a party authored this brief in whole or in part and no person or entity other than amicus curiae, its members, and its counsel contributed monetarily to the preparation or submission of this brief.

to rely on the presumption. But where the statute is ambiguous, the Court must determine whether a state law is within the preempted domain. In those cases, the presumption guides the Court to favor the nonpreemptive reading of the statute.

In this case, the Court has already determined that the express preemption provision at issue is ambiguous. The Missouri Supreme Court properly accepted the interpretation that disfavors preemption of Missouri's antisubrogation law.

2. The presumption against preemption, particularly in areas traditionally occupied by the states, safeguards the role of the sovereign states in the federalist system. This Court has held that protection of the interests of the states is entrusted to their representatives in Congress. For that reason, to avoid unintended incursion into state governance, courts must insist that Congress speak plainly when it intends to preempt state law.

This Court has long recognized that the states have traditionally exercised their police power authority to protect the health and safety of their citizens through the application of state tort law. The OPM rule interferes with state tort rules, upsetting the complex balancing of state interests and policies that is reflected in the tort law of each state.

For example, the OPM rule is not directed solely at reimbursement out of payments by parties responsible for the beneficiary's injuries. The rule specifically requires reimbursement out of any applicable insurance or workers' compensation benefits paid to the beneficiary, including proceeds of insurance

coverage paid for entirely by the federal employee or beneficiary, thereby undermining state policies that encourage individuals to insure themselves against unexpected illness or injury. The rule also requires that FEHBA carriers be reimbursed first, before the injured victims is compensated for his or her injuries, essentially shifting the burden of paid medical expenses from FEHBA carriers, who have received premiums to provide coverage for such expenses, to other insurers who have compensated the plaintiff for other losses.

Most importantly, the OPM rule is not directed at repaying FEHBA carriers out of a "double recovery" by injured beneficiaries. In fact, it is more likely that injury victims will not receive a single recovery of full compensation so that reimbursement of the FEHBA carrier may leave the federal employee or family member undercompensated for their loss.

The rule's assumption that tort awards fully compensate plaintiffs is plainly erroneous. It is well established that seriously injured plaintiffs generally are awarded only a portion of their financial losses. Secondly, payment of tort awards or settlements is often limited to the amount available under the tortfeasor's liability insurance coverage. Finally, most states have reduced recoveries for plaintiffs, sometimes substantially, through "tort reform" measures. For example, many states impose caps on recoverable damages, which can significantly reduce compensation for plaintiffs with severe injury. Nonetheless, the OPM rule entitles the carrier to 100 percent reimbursement out of a tort judgment or settlement.

Many states have also eliminated or modified the doctrine of joint and several liability. As a result, plaintiff's recovery will be reduced by the percentage of liability assigned to a joint tortfeasor who is immune from suit, insolvent, or otherwise unavailable to respond for their share of damages. Yet the OPM rule requires 100 percent reimbursement for the FEHBA carrier.

Most states have also abolished or restricted the collateral source rule, under which the tortfeasor was required to compensate the plaintiff for medical expenses due to wrongful injury, even though the plaintiff's health insurance paid those expenses. To eliminate the possibility of double recoveries, states have authorized the jury or trial judge to subtract the plaintiff's health insurance benefits from the tort award. By definition, those plaintiffs receive no more than a single recovery. It makes no economic sense to require reimbursement out of plaintiff's compensation for other harms, leaving the plaintiff worse off than if he or she had not sued at all.

States' efforts to protect their citizens from the harsh consequences of subrogation and reimbursement reflect individual state policy decisions. Some, like Missouri, prohibit subrogation in personal injury cases. Other states seek to mitigate the harsh impact of subrogation by adopting the made-whole doctrine or the common-fund rule. Congressional lawmakers are cognizant of these important state policies and would not have intended to undermine them by overriding state limitations on subrogation.

Congress also would not have intended to discourage victims of wrongful conduct from holding

tortfeasors accountable, thereby undermining a central objective of state tort law – deterrence of unreasonably dangerous behavior. The increase in accidental injury will necessarily increase the medical expenses paid out by FEHBA carriers.

3. Subrogation/reimbursement is not the effective or appropriate cost-containment measure that OPM suggests. First, although FEHBA carriers may have obtained $126 million in subrogation recoveries, there is no showing that this sum was used to reduce the federal government's portion of the cost of the program or to reduce the premiums paid by enrollees. Community-rated carriers, such as the carrier in this case, are not required to remit any of their subrogation recoveries to the Treasury Fund which funds the program. The fact that recoveries may reduce a carrier's costs does not translate into a direct causal connection with lower premiums. In the private sector, health insurers generally do not take the speculative possibility of future subrogation into account when setting rates.

Experience-rated carriers are required to place such recoveries into the Treasury Fund, net of expenses incurred to obtain those recoveries. Those expenses, such as the percentage of recoveries turned over to third-party collection services, can be substantial. Th claim that subrogation saves significant amounts for the federal government and enrollees should not be credited in the absence of quantification. In any event, even if the entire $126 million recovery were devoted to reducing premiums, the savings would be vanishingly small.

More fundamentally, this justification for subrogation is inconsistent with Congress's intent in establishing the health insurance program for federal employees. It is true that the intent of Congress is the touchstone in ascertaining the scope of federal preemption. But the Court does not look to the express preemption provision in isolation. Rather, the Court looks to the purpose of the statute as a whole and the way Congress intended the statute to operate.

Congress enacted the FEHBA to provide federal government employees with protection against the financial burden of high medical costs through a program of insurance paid for by the federal government and federal workers. Insurance provides such protection by allowing a large pool of individuals who have not yet suffered loss to pay a relatively modest premium so that the few individuals among them who do suffer loss can be provided with compensation. The OPM rule operates on the opposite premise. It takes away compensation from those individuals who have suffered loss in order to provide a very small financial benefit to the pool of uninjured individuals. This was not the purpose of Congress in establishing an insurance program for federal employees. This is insurance running in reverse.

ARGUMENT

I. THE PRESUMPTION AGAINST PREEMPTION COUNSELS THE COURT TO READ EXPRESS PREEMPTION STATUTES NARROWLY AND ACCEPT THE READING THAT DISFAVORS PREEMPTION.

One of the "cornerstones of [this Court's] preemption jurisprudence" is the guiding principle that "[i]n *all* pre-emption cases, and particularly in those in which Congress has 'legislated in a field which the States have traditionally occupied, we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Wyeth v. Levine*, 555 U.S. 555, 565 (2009) (emphasis added), quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (internal quotations and citations omitted).

The U.S. Chamber of Commerce as amicus urges this Court to upend this longstanding principle in express preemption cases, suggesting that this Court's reliance on the presumption "has waned in the express preemption context." Brief for the Chamber of Commerce of the United States of America ("Chamber Br.") 5, quoting *Altria Group, Inc. v. Good*, 555 U.S. 70, 99 (2008) (Thomas, J., dissenting). In the Chamber's view, "there is neither need nor basis for a presumption against preemption when interpreting statutes that expressly reflect a Congressional judgment to preempt state law." *Id. See also* Brief for Petitioner ("Pet. Br.") 36 ("The presumption against preemption is irrelevant because Section 8902(m)(1) is an express preemption provision.").

This Court has already rejected the Chamber's argument.

> Although dissenting Justices have argued that this assumption should apply only to the question whether Congress intended any pre-emption at all, as opposed to questions concerning the scope of its intended invalidation of state law, we used a "presumption against the pre-emption of state police power regulations" to support a narrow interpretation of such an express command in *Cipollone* [*v. Liggett Group, Inc.*, 505 U.S. 504, 518 (1992)].

Medtronic, 518 U.S. at 485 (internal citation omitted). This Court has consistently instructed that the presumption applies "[w]hen addressing questions of *express* or implied preemption." *Altria Group*, 555 U.S. at 77 (emphasis added).

Although the burdens may differ, the question facing a court when a defendant raises express preemption as a defense to enforcement of state law is not different in kind from an implied preemption defense. In either case, the court must determine whether the particular federal statute supersedes a particular state law. Congress may have expressed its intent to supersede state law to some extent, but whether the state law at issue falls within the scope of that preemption is often unclear. As this Court has explained, when "presented with the task of interpreting a statutory provision that expressly pre-empts state law" the Court "need not go beyond that language to determine whether Congress intended . . . to pre-empt at least some state law," but "must nonetheless 'identify the domain expressly pre-empted"

by that language,'" *Medtronic,* 518 U.S. at 484, quoting *Cipollone,* 505 U.S. at 517. *See also Altria Group.,* 555 U.S. at 76 (Even where Congress has expressly preempted some state law, "the question of the substance and scope of Congress' displacement of state law still remains.").

Thus, where the text of the statute clearly and unambiguously shows that Congress intended to preempt the state law at issue, "the courts' task is an easy one." *English v. General Elec. Co.,* 496 U.S. 72, 79 (U.S. 1990). The presumption cannot save an unambiguous expression of Congress' intent. But "when the text of a pre-emption clause is susceptible of more than one plausible reading, courts ordinarily 'accept the reading that disfavors pre-emption.'" *Altria Group,* 555 U.S. at 77 (2008), quoting *Bates v. Dow Agrosciences LLC,* 544 U.S. 431, 449 (2005).

This Court has consistently applied this principle in express preemption cases. In addition to *Altria Group, Bates, Medtronic,* and *Cipollone, supra, see Riegel v. Medtronic, Inc.,* 552 U.S. 312, 334 (2008); *Lorillard Tobacco Co. v. Reilly,* 553 U.S. 525, 54 (2001); *New York Conference of Blue Cross v. Travelers Insurance,* 514 U.S. 645 (1995); and *CSX Transp., Inc. v. Easterwood,* 507 U.S. 658, 668 (1993). *See also CTS Corp. v. Waldburger,* 134 S. Ct. 2175, 2188 (2014) (Kennedy, J., concurring) (terming the principle of accepting the reading of an express provision that disfavors preemption one of this Court's "well-established presumptions about the nature of preemption").

The Chamber, however, contends that this Court discarded the presumption in practice in several recent

cases. Chamber Br. 6-8. To the contrary, the Court in those cases adhered to its cornerstone preemption principle that where the statutory text is ambiguous and susceptible of more than one plausible reading, the presumption favors the non-preemptive interpretation. For example, in *Riegel v. Medtronic, Inc.*, 552 U.S. 312 (2008), the Court found it unnecessary to rely on the presumption "because we think the statute itself speaks clearly to the point." *Id.* at 326. Similarly in *Bruesewitz v. Wyeth LLC*, 562 U.S. 223 (2011), Wyeth relied on the express preemption provision in the National Childhood Vaccine Injury Act. Although the majority and the dissent disagreed over the meaning of the statutory text, neither suggested that the text was ambiguous. The majority stated that because "our interpretation of [the express preemption provision] is the only interpretation supported by the text and structure of the NCVIA," there was no need to rely on the presumption for statutory interpretation. *Id.* at 240.

Nor does *PLIVA, Inc. v. Mensing*, 564 U.S. 604 (2011), support the Chamber's contention. The Court there held that plaintiff's state law cause of action against the manufacturer of a generic drug for failure to warn was preempted because if the manufacturers had altered the FDA-approved warnings, "they would have violated federal law." *Id.* at 618. *Mensing* was an instance of conflict preemption due to impossibility, and the Court had no occasion to rely on the presumption against express preemption.

The Chamber also looks to *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016), which involved a Vermont law requiring ERISA health plans to submit

detailed reports concerning enrollees and claims to a state agency. Although Justice Kennedy discussed the presumption against preemption, he did not focus on ambiguity in the statutory text. Rather, the Court held that the Vermont law was preempted by ERISA because it constituted "direct regulation of a fundamental ERISA function." *Id.* at 946.

Finally, in *Puerto Rico v. Franklin California Tax-Free Trust*, 136 S. Ct. 1938 (2016), the issue was whether Puerto Rico is a "State" for purposes of the preemption provision in the federal Bankruptcy Code. This Court found it unnecessary to "invoke any presumption against preemption" because "the statute's language is plain." *Id.* at 1946.

In this case, the preemption provision in the Federal Employee Health Benefit Act ["FEHBA"] is far from plain. The provision states:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

This Court previously examined this provision and found it "a puzzling measure, open to more than one construction." *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 697 (2006). However, the Court determined that to decide that case, "we need not choose between those plausible constructions." *Id.* at 698. The Missouri Supreme Court in this case was

required to make that choice, and properly accepted the reading that disfavors preemption. *Nevils v. Group Health Plan, Inc.*, 418 S.W.3d 451, 455 (Mo. 2014) (en banc). That interpretation faithfully followed this Court's cornerstone preemption principle.

II. THE OPM RULE DISTURBS THE ALLOCATION OF TORT LIABILITY IN AN AREA TRADITIONALLY OCCUPIED BY THE STATES AND UPSETS THE STATES' BALANCE OF COMPETING POLICIES AND INTERESTS.

A. Preempting State Law Only Where Congress Has Unambiguously Stated Its Intent To Do So Safeguards the Role of the States In the Federalist System.

The presumption against preemption is not merely a rule of statutory construction, but a principle "consistent with both federalism concerns and the historic primacy of state regulation of matters of health and safety." *CTS Corp.*, 134 S. Ct. at 2189 (Kennedy, J. concurring), quoting *Medtronic*, 518 U.S. at 485.

This principle "has two dimensions: Courts must be careful not to give an unduly broad interpretation to ambiguous or imprecise language Congress uses. And they must confine their opinions to avoid overextending a federal statute's pre-emptive reach." *Arizona v. Inter Tribal Council of Arizona, Inc.*, 133 S. Ct. 2247, 2261 (2013) (Kennedy, J., concurring). Error on either front "may put at risk the validity and effectiveness of laws that Congress did not intend to disturb and that a State has deemed important to its scheme of governance." *Id.*

For this reason, "the assumption 'that the historic police powers of the States [are] not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress' applies with particular force when Congress has legislated in a field traditionally occupied by the States." *Altria Group,* 555 U.S. at 77, quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). In this way, the presumption in favor of non-preemption "provides assurance that the federal-state balance . . . will not be disturbed unintentionally by Congress or unnecessarily by the courts." *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977). *See also CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 664 (1993) (The presumption against preemption preserves healthy federalism by "avoiding unintended encroachment on the authority of the States.").

Requiring Congress to make the scope of preemption clear and unambiguous is the natural corollary to this Court's rejection of judicially managed protection of the integrity of the states in the federalist system. In *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985), this Court held that the role of the sovereign states is instead "more properly protected by the procedural safeguards inherent in the structure of the federal system," that is, by the representation of their interests by elected members of Congress when crafting federal statutes. *Id.* at 551-52. If it is the responsibility of Congress to avoid undue federal interference with the states' protection of the health and wellbeing of their citizens, then it is incumbent upon the courts to insist that Congress speak plainly when it legislates in that area. As Justice O'Connor observed,

> [I]nasmuch as this Court in *Garcia* has left primarily to the political process the protection of states against intrusive exercises of Congress's Commerce Clause powers, *we must be absolutely certain that Congress intended such an exercise*. "To give the state-displacing weight of federal law to mere congressional ambiguity would evade the very procedure for lawmaking on which *Garcia* relied to protect states' interests."

Gregory v. Ashcroft, 501 U.S. 452, 464 (1992), quoting Lawrence Tribe, American Constitutional Law § 6-25, at 480 (2d ed. 1988) (emphasis added). *See also United States v. Bass*, 404 U.S. 336, 349 (1971) ("[U]nless Congress conveys its purpose clearly, it will not be deemed to have significantly changed the federal-state balance.").

The Chamber does not entirely disagree. It acknowledges that the rationale for the presumption against preemption is respect for the principles federalism and for state sovereignty. Chamber Br. 12. The Chamber insists, however, that "the forum for addressing federalism questions is the Capitol, not the courthouse." *Id.* As this Court made clear in *Gregory v. Ashcroft*, if Congress is to strike the proper balance between federal government and the states, courts must require that Congress speak plainly and unambiguously when it exercises its preemptive authority.

B. The OPM Rule Interferes with the Balancing of Policies and Interests Reflected in State Tort Law.

1. *The compensation of wrongfully injured individuals is an area traditionally occupied by the states.*

The United States, while conceding that there is a strong presumption against preemption when Congress legislates in an area traditionally occupied by the states, argues this is not such a case. Rather, "this dispute concerns benefits from a federal health insurance plan for federal employees that arise from a federal law." Brief for the United States ("U.S. Br.") 26. In the Solicitor General's view, "there is hardly an area in which a state would have less of a legitimate interest than this employment relationship." *Id.* at 27, quoting *Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1100 (10th Cir. 2015).

To the contrary, barring or limiting reimbursement of a private insurer out of damages awarded in a state tort suit hardly interferes with the federal employment relationship. But preempting such state law across the board does interfere with the complex balancing of competing policies and interests that each state undertakes in developing its law of torts. "Throughout our history," this Court has stated, "the several States have exercised their police powers to protect the health and safety of their citizens." *Medtronic,* 518 U.S. at 475. "In our federal system, there is no question that States possess the 'traditional authority to provide tort remedies to their citizens' as they see fit." *Wos v. E.M.A.*, 133 S. Ct. 1391, 1400 (2013), quoting *Silkwood v. Kerr–McGee Corp.*, 464 U.S. 238, 248 (1984). Hence,

federal law must take into account the "legitimate and substantial interest of the State in protecting its citizens" through tort liability. *Farmer v. United Bhd. of Carpenters & Joiners of America*, 430 U.S. 290, 304 (1977).

2. The OPM rule undermines the states' interest in encouraging individuals to insure against harm.

The United States appears to argue that the OPM rule does not undermine the goal of state tort law in compensating victims of wrongful conduct. In the stated view of the Solicitor General, subrogation, which under the OPM contract encompasses reimbursement, U.S. Br. 4, "occurs when the insurer demands repayment from an insured who has recovered twice for the same injury, once from the insurer and again from a third party who caused the loss." *Id.* This is a fundamentally erroneous representation of both the OPM contract and state tort rules.

First, the OPM contract does not limit carriers to reimbursement from funds "from a third party who caused the loss." Indeed, OPM in response to carrier comments on the proposed rule, removed the limitation that reimbursement be obtained from funds paid by a "responsible third party." *See* Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery, 80 Fed. Reg. 29,203, 29,203 (May 21, 2015) ("*Final Rule*"). Instead, the final rule requires carriers to seek reimbursement not only from "payment from any party that may be liable" but also from "any applicable insurance policy, or a workers' compensation program or insurance policy." 5 C.F.R. § 890.101(a). *See also id.* at § 890.106(c) (providing that

contracts must provide that the carrier's right to subrogation or reimbursement arises when the covered individual "is entitled to receive compensation or recovery on the basis of the illness or injury," from any source, "including from insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the enrollee or a covered family member."). This change was specifically directed at allowing reimbursement from uninsured or underinsured motorist coverage paid for entirely by the injured individual. *Final Rule*, 80 Fed. Reg. at 29203. To the extent that the proceeds of plaintiff's own insurance coverage may be diverted to reimburse FEHBA carriers, the rule operates as a disincentive for individuals to insure themselves.

The rule also provides that the carrier may take its reimbursement from a judgment or settlement "first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. 5 C.F.R. § 890.106(c). In other words, the carrier is entitled to recoupment from the entire judgment or settlement before the plaintiff receives any compensation. Also, it may recoup paid medical expenses from those portions of plaintiff's tort award that were intended to compensate for pain and suffering, lost wages, or property damage. Essentially, the OPM rule shifts the cost of medical expenses paid by the FEHBA carrier to other insurers that did not cause the plaintiff's medical expense or to plaintiff's compensation for other, nonmedical losses.

3. *The OPM rule is not addressed to the relatively rare occurrence of "double recovery."*

The claim that subrogation or reimbursement simply comes out of the pocket of "an insured who has recovered twice for the same injury," U.S. Br. 4, is a misrepresentation of the reality of state tort liability. Double-recovery is a rare occurrence. In fact, it is far more likely that a seriously injured plaintiff who prevails at trial will not receive even a single recovery for the full extent of his or her injuries.

First, "scholarly research documents that more seriously injured victims tend to recover only a part of their total financial losses, notwithstanding the supposed legal entitlement to full compensation." Kenneth S. Abraham, Robert L. Rabin, and Paul C. Weiler, *Enterprise Responsibility for Personal Injury: Further Reflections,* 30 San Diego L. Rev. 333, 340 (1993). In fact, the consistent "undercompensation [of personal injury plaintiffs] at the higher end is so well replicated that it qualifies as one of the major empirical phenomena of tort litigation." Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System-And Why Not?* 140 U. Pa. L. Rev. 1147, 1218 (1992).

Second, whether the plaintiff has obtained a verdict or a settlement, he or she is often limited to the amount available from the defendant's liability insurer. Far from double recovery, a plaintiff must often settle for a fraction of a single recovery.

Finally, most states have enacted tort rules that limit compensation in order to serve other state

objectives, such as mitigating a perceived liability insurance "crisis," or shielding a group that the state seeks to attract, such as physicians, from full liability for misconduct. *See generally*, Avraham Ronen, *Database of State Tort Reforms*, Northwestern L. & Econ. Res. Paper No. 06-08 (2014) (extensive state-by-state compilation of tort reform legislation enacted after 1980), available at http://ssrn.com/abstract=902711. The effect of these "tort reform" measures is to reduce amount a plaintiff may recover, sometimes far below his or her actual damages.

For example, many states impose a ceiling on the amount of damages that may be awarded to a plaintiff in certain cases. *See* Ronen, *supra*, listing 34 states that limit recoverable damages, most commonly noneconomic damages in medical malpractice cases. These caps significantly reduce both verdicts and settlements. *See* David A. Hyman, Bernard Black, Charles Silver, William M. Sage, *Estimating the Effect of Damages Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. Legal Analysis 355, 405-06 (2009). In addition, they often disproportionately undercompensate those plaintiffs who can least afford it. *See* Robert S. Peck, *Violating the Inviolate: Caps on Damages and the Right to Trial by Jury*, 31 U. Dayton L. Rev. 307, 337-41 (2006). The OPM rule allows the FEHBA carrier to insist on reimbursement "first" from plaintiffs who have not received a double recovery, but who may have been significantly undercompensated for their actual losses.

Another frequent target of tort reform legislation is the doctrine of joint and several liability. At common law, where two or more persons are liable for a single

and indivisible harm, the plaintiff can recover the entire amount of damages from any of them. Restatement (Second) of Torts § 875 (1979). The plaintiff is entitled to only one recovery, but the fact that one joint tortfeasor is immune from suit, insolvent, or otherwise unavailable does not reduce the liability of another joint tortfeasor for the full amount. *See Id.* at § 880.

Most states have at least partially abolished this common-law doctrine. *See* Nancy C. Marcus, *Phantom Parties and Other Practical Problems with the Attempted Abolition of Joint and Several Liability*, 60 Ark. L. Rev. 437, 441 (2007) (indicating that 35 states have done so). A typical tort reform measure limits a joint tortfeasor's liability to the percentage of fault allocated by the jury. *See, e.g.*, Thomas A. Eaton, *Who Owes How Much? Developments in Apportionment and Joint and Several Liability Under O.C.G.A. S 51-12-33*, 64 Mercer L. Rev. 15 (2012) (Georgia law). Some states allow allocation of some percentage of fault to nonparties, including those immune from suit. *See id.* at 15 & n. 14. The result is to shift to the plaintiff the risk that one or more joint tortfeasors is not answerable in damages. Yet, even if the plaintiff can recover only a fraction of her actual damages, the OPM rule provides that the carrier be reimbursed for 100 percent of its paid medical benefits, leaving plaintiff with little or no compensation for her other losses.

Limitations on the collateral source rule are also of particular import. The prevailing rule at common law required a tortfeasor to compensate the plaintiff for medical expenses resulting from wrongful injury, regardless of whether those expenses were also covered

by the plaintiff's health plan or insurer. Restatement (Second) of Torts § 920A(2) (1979). *See generally*, Richard C. Maxwell, *The Collateral Source Rule in the American Law of Damages*, 46 Minn. L. Rev. 669 (1962). Most states have abolished or altered that rule as well. The American Tort Reform Association, which tracks such legislation, reports that 27 states have done so. See ATRA, Phantom Damages Reform, available at http://www.atra.org/issue/phantom-damages-reform/.

State legislation restricting the collateral source rule closely tracks the state's policy judgments. Some statutes are applicable in all personal injury cases, while others affect specific tort actions. *See, e.g.*, Cal. Civ. Code § 3333.1 (medical malpractice cases). Some admit evidence of collateral source payments for the jury's consideration in determining damages. *E.g.*, Colo. Rev. Stat. § 13-21-111.6. Others require the court to deduct such amounts from the verdict before entering judgment. *E.g.*, N.J. Stat. Ann. §2A:15-97 (2000); 40 Pa. Cons. Stat. Ann. § 1303.508.

The purpose of abolishing or restricting the collateral source rule is a state policy decision "to shift the burden, at least to some extent, from the liability and casualty insurance industry to health and disability third-party payers," overriding insurers' right to subrogation. *Perreira v. Rediger*, 778 A.2d 429, 436-37 (N.J. 2001). With these state policy decisions in mind, the OPM rule makes little economic or equitable sense. The rule takes a state tort verdict or settlement from which plaintiff's paid medical benefits have been deducted, then requires plaintiff to reimburse her FEHBA insurer out of that reduced award. *Cf.*

2 American Law Inst., Reporters' Study: Enterprise Responsibility for Personal Injury 182 (1991) (In its thorough examination of the tort system, the ALI states that, for its recommendation to abolish the collateral source rule to make economic sense, "there must be a bar to any subrogation or reimbursement rights exercised by loss insurers against the tort award.").

Lawmakers in Congress surely were aware of these tort reform policy decisions in their states. They could not have intended broad preemption of state antisubrogation laws which would upset those policy decisions without any discussion of subrogation. In addition, Congress could not have intended that federal workers who have been wrongfully injured could face the prospect of recovering little or even becoming financially worse off after successfully holding the tortfeasor liable.

4. The OPM rule undermines state efforts to protect their citizens from the harsh consequences of subrogation and reimbursement.

Due to the harsh impact on victims of wrongful injury, courts at common law prohibited subrogation of personal injury recoveries to recoup medical expenses, until relatively recently. *See* Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D.L. Rev. 237, 239-40 (1996). *See, e.g., Allstate Ins. Co. v. Reitler*, 628 P.2d 667, 670 (Mont. 1981), and *Maxwell v. Allstate Ins. Cos.*, 728 P.2d 812, 815 (Nev. 1986) (both holding plan provisions requiring reimbursement of medical payments void as against public policy). A number of states also banned

subrogation legislatively. *See* Brief For Amici Curiae America's Health Insurance Plans and Association of Federal Health Organizations ("AHIP Br.") 16 (citing anti-subrogation statutes).

Nearly all states that permit subrogation/reimbursement have taken steps to shield their citizens from subrogation's harshest effects. Unsurprisingly, each state strikes a different balance between the interests of injured plaintiffs and first-party insurers, resulting in a "patchwork" of legal and equitable doctrines designed to serve each state's policy judgments. AHIP Br. 16. The two most common doctrines that protect consumers are the "made-whole" doctrine and the "common-fund" rule. Roger M. Baron & Anthony P. Lamb, *The Revictimization of Personal Injury Victims by ERISA Subrogation Claims*, 45 Creighton L. Rev. 325, 330 (2012).

The made-whole doctrine sensibly requires that the plaintiff be compensated for his or her losses before the insurer is repaid for benefits provided. Currently, the overwhelming majority of states that allow reimbursement have adopted the made-whole doctrine. *See* Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723 (2005) (summarizing the laws of 32 states applying the doctrine); *see also* David M. Kono, *Unraveling the Lining of ERISA Health Insurer Pockets--A Vote for National Federal Common Law Adoption of the Make Whole Doctrine*, 2000 B.Y.U.L. Rev. 427, 437 (2000).

It is unlikely Congress would have intended to authorize carriers providing health insurance to federal employees to institute actions that were historically

prohibited at common law and which are so antithetical to public policy that the overwhelming majority of states either ban such actions or permit them only after the insured has been made whole. Certainly Congress would not have taken such a drastic step without discussion.

Many states also apply the "common-fund" rule in reimbursement/subrogation cases. *See generally* Association Of Federal Health Organizations, State Survey of Reimbursement Laws in The Health Insurance Context (Feb. 2014), available at http://ermerlaw.com/PDFs/Feb2014%20FHOStateSurveyWithMap.pdf at 1 (map identifying "common-fund" states).

Under this rule, "a litigant or lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as a whole." *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1545 (2013) (internal quotation marks and citation omitted). By not requiring FEHBA carriers who are reimbursed out of a judgment or settlement to pay a portion of the plaintiff's attorney fee, as Chief Judge Posner has pointed out, the carrier is allowed "to free ride on the efforts of the [beneficiary's] attorney." *Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Wells*, 213 F.3d 398, 402 (7th Cir. 2000). It might also leave a plaintiff "worse off . . . than she would have been had she not sued" at all. *Id.*

By discouraging FEHBA beneficiaries from pursuing meritorious tort lawsuits, the OPM rule undermines the other policy objective of state tort law: the deterrence of unreasonably dangerous conduct and

the promotion of investment in safety. *See* American Bar Association, Towards a Jurisprudence of Injury 4-3 (1984) (deterrence of misconduct is "a strong thread running through tort law"); Guido Calabresi, The Costs of Accidents 68-129 (1970) (tort liability acts as specific and general deterrent to accidents); Gary T. Schwartz, *Deterrence and Punishment in the Common Law of Punitive Damages,* 56 S. Cal. L. Rev. 133, 137 (1982) ("There is now a rich body of academic literature supporting the view that a primary purpose of tort liability rules is to discourage inappropriate behavior on the part of accident causers.").

The OPM rule undermines this deterrence, leading inevitably to an increase in accidental injuries. Some of the resulting medical expenses, of course, will be paid by FEHBA carriers and paid for by the federal government and federal workers.

In sum, the issue here is not a matter of undoing double recoveries. Rather, the question is: Who shall bear the risk that a tort recovery will not be sufficient to make the plaintiff whole for his or her injuries? *See, e.g.*, Jeffrey A. Greenblatt, *Insurance and Subrogation: When the Pie Isn't Big Enough, Who Eats Last?*, 64 U. Chi. L. Rev. 1337 (1997). Amicus submits that the medical benefits plan, which has accepted payment for coverage of the beneficiary's medical expenses and is in the business of spreading the costs of medical expenses, is the appropriate party to bear that risk. This is consistent with the intent and purpose of Congress in creating a program to provide insurance to federal employees.

III. SUBROGATION/REIMBURSEMENT IS NOT AN EFFECTIVE OR APPROPRIATE COST-CONTAINMENT MEASURE.

A. Savings To the Federal Government and Federal Employees Is Vanishingly Small.

The primary policy argument advanced in support of the broad subrogation/reimbursement rule promulgated by OPM is that the income recovered back from injured beneficiaries reduces the costs that must be borne by the federal government and health plan participants. Pet. Br. 33 (Such recoveries "translate to premium cost savings for the federal government" (thus taxpayers) and FEHB enrollees."), quoting OPM, *Final Rule*, 80 Fed. Reg. at 29,203. *See also* U.S. Br. 19 (similar); AHIP Br. 12-14 (similar).

In support of its subrogation rule as a cost-savings measure, OPM boasts that in 2014, "FEHB carriers were reimbursed by approximately $126 million in subrogation recoveries." *Final Rule*, *supra*. However, neither OPM nor the Solicitor General indicate how much of those recoveries actually went to the Treasury Fund or was used to reduced premiums.[2]

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[2] AHIP erroneously states that "that reimbursement and subrogation recoveries save the FEHB Program – and the enrollees and taxpayers who fund it – over $125 million per year." AHIP Br. 14. In fact, OPM explicitly states that its figure represents the amount recovered by carriers. It is unknown how much of that amount, if any, was savings to the federal government and enrollees.

AHIP explains that FEHBA carriers charge for health coverage in two ways. Petitioner in this case is a community-rated entity which "receives a 'per member per month capitation rate' for each member enrolled in the plan." AHIP Br. 8, quoting 42 C.F.R. § 1602.170-2. Community-rated carriers are not required to return any money recovered in subrogation to the Treasury Fund *See* Pet. Br. 11. Nevertheless, AHIP contends that subrogation/reimbursement by community-rated carriers results in savings because the "premiums that community-rated carriers charge generally depend on the expected cost of providing benefits," and subrogation recoveries "tend to reduce those expected costs, and thus the premiums." AHIP Br. 14.

AHI offers no documentation of any direct relationship between subrogation recoveries and reduced premiums. In the private sector, as one authority states, "simply because an insurer has the opportunity to recover reserves and become financially healthy, this opportunity does not directly translate into premium reductions." Roger M. Baron, *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 Mercer L. Rev. 595, 630 (2004).

Professor Baron explains:

> The prospect of a successful subrogation collection is not a factor in the insurer's rate determination. In fact, the conjectural and remote nature of subrogation militates against its inclusion as a factor for consideration in the setting of premium rates.

Roger M. Baron, *Pandora's Box*, 41 S.D.L. Rev. at 244. *See also* Keith E. Edeus, Jr., *Subrogation of Personal Injury Claims: Toward Ending an Inequitable Practice*, 17 N. Ill. U. L. Rev. 509, 515 (1997) (Health insurance "premiums themselves are calculated based upon the losses actually incurred, . . . and do not take subrogation recoveries into account."). The fact is, there are other uses for subrogation receipts. *See* Scott M. Aronson, *ERISA's Equitable Illusion: The Unjustice of Section 502(a)(3)*, 9 Employee Rights & Employment Policy J. 247, 286 (2005) ("Subrogation recoveries are used to increase executive compensation or shareholder dividends, not to decrease premiums.").

Experience-rated plans, by contrast, receive premiums based on "actual paid claims." AHIP Br. 8. Such plans "must return all reimbursement and subrogation recoveries (net of the expenses in obtaining the recoveries) directly to the Treasury Fund set up to finance the FEHB Program." AHIP Br. 13.

Of course, "net of the expenses in obtaining the recoveries" can diminish the amount returned to the Treasury Fund substantially. The task of recovering such reimbursements is often outsourced to third party collectors. In this case, for example, the carrier retained ACS Recovery Services, Inc. for that purpose. Indeed, a recoupment industry has developed to pursue those who have received health insurance benefits for possible reimbursement. Most companies specializing in obtaining reimbursement for health benefit plans "charge based on a tiered pricing model, which can range from 20-40%" of the recovery. Sedgwick Claims Management Services, *Central Subrogation* (2012), *available at* https://www.sedgwickcms.com/services/

docs/SubrogationOverview.pdf. In addition, the carrier is entitled to cover its own administrative costs and attorney fees. Neither Petitioner nor supporting amici provide figures that would support the proposition that experience-rated carriers return substantial amounts to the program's Treasury Fund out of subrogation/reimbursement recoveries or that community-rated carriers have appreciably reduced their premiums.

Even if the entire $126 million recovery were applied to the program, with no deductions for the carriers' costs and fees, the savings would be vanishingly small. OPM states that the federal government's 70 percent share of the program's cost amounted to about $33 billion in 2014, so the entire cost for the government and enrollees was approximately $47.1 billion. $126 million would represent a savings for the program of about $2.60 annually for every $1,000 in premiums.

B. The OPM Rule Requiring Injured Individuals To Bear the Financial Burden of Injury In Order To Allow Uninjured Enrollees a Small Savings Is Inconsistent With the Health Insurance Plan Congress Put In Place.

Even accepting for the moment the contention that the OPM rule would result in a small reduction in the premiums paid by federal workers and the federal government, the rule is inconsistent with Congress's purpose in enacting the FEHBA.

It is a truism that in ascertaining the scope of federal preemption of state law, "the purpose of

Congress is the ultimate touchstone." *Medtronic,* 518 U.S. at 485, citing *Cipollone*, 505 U.S. at 516. The United States argues that "Section 8902(m)(1) advances Congress's goals of 'reducing health care costs,'" U.S. Br. 19, quoting OPM, *Final Rule*, 80 Fed. Reg. at 29,203.

This is too narrow a view. The inquiry into the intent of Congress does not focus on the preemption provision in isolation. As this Court has explained, congressional intent is discerned not only from the text of the preemption provision but also from "the structure and purpose of the statute as a whole." *Medtronic*, 518 U.S. at 486. The reviewing court must bring to this inquiry its "reasoned understanding of the way in which Congress intended *the statute and its surrounding regulatory scheme* to affect business, consumers, and the law." *Id.* (emphasis added).

Congress's stated goal when it enacted FEHBA in 1959 was to provide

> [P]rotection for civilian Government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive government-wide program of insurance for federal employees . . . the costs of which will be shared by the Government, as employer, and its employees.

H.R. Rep. No. 86–957, at 1 (1959), reprinted in 1959 U.S.C.C.A.N. 2913, 2914.

The principle of insurance allows a large pool of individuals who have not yet suffered loss to pay a relatively modest amount so that a few individuals among them who do suffer loss will be compensated.

OPM's subrogation rule is quite the opposite. It takes away compensation from those who have suffered loss in order to confer a very small financial benefit on the pool of uninjured individuals This was not the intent of the FEHBA and its surrounding regulatory scheme. This is insurance running in reverse.

Congress certainly did not intend for its insurance program for federal employees to operate this way. Congress did not intend to save money by shifting costs to workers compensation or other insurance. It did not intend to discourage individuals from holding tortfeasors accountable for the harms they cause.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment of the Missouri Supreme Court.

Respectfully submitted,

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In The Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ Of Certiorari To The Supreme Court Of Missouri

BRIEF FOR *AMICI CURIAE* AMERICA'S HEALTH INSURANCE PLANS AND ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS IN SUPPORT OF PETITIONER

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BRIEF FOR *AMICI CURIAE* AMERICA'S HEALTH INSURANCE PLANS AND ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS IN SUPPORT OF PETITIONER

America's Health Insurance Plans ("AHIP") and Association of Federal Health Organizations ("AFHO") respectfully submit this brief as *amici curiae* in support of petitioner, with the written consent of the parties.[1]

STATEMENT OF INTEREST OF *AMICI CURIAE*

America's Health Insurance Plans ("AHIP") is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable healthcare coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Along with its predecessors, AHIP has over 50 years' experience in the industry. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare, Medicaid, and – as relevant here – the Federal Employees Health Benefit

[1] Counsel for *amici* has filed the requisite consent letters with the Clerk. No party or counsel for a party authored this brief in whole or in part, and no counsel or party, or any person other than *amici*, their members, and counsel, made a monetary contribution intended to fund the brief's preparation or submission.

("FEHB") Program. As a result, AHIP's members have broad experience working with hospitals, physicians, patients, employers, state governments, the federal government, pharmaceutical and device companies, and other healthcare stakeholders to ensure that patients have access to needed treatments and medical services. That experience gives AHIP extensive first-hand and historical knowledge about the Nation's healthcare and health insurance systems and a unique understanding of how those systems work.

The Association of Federal Health Organizations ("AFHO") is an organization of entities that serve as carriers of health benefit plans under the FEHB Program. Collectively, the plans of AFHO member carriers provide health benefits to over 3 million federal and postal employees and annuitants who receive health coverage under the FEHB Program.

Amici and their members have a demonstrated interest in ensuring that courts correctly interpret and apply federal health benefit statutes, including the Federal Employees Health Benefits Act ("FEHBA"). *See, e.g.*, *Health Care Serv. Corp. v. Pollitt*, 559 U.S. 965 (2010) (AHIP and AFHO participated as *amici* in FEHBA case dismissed pursuant to Supreme Court Rule 46.1); *see also Hillman v. Maretta*, 133 S. Ct. 1943 (2013) (AFHO filed *amicus* brief in preemption case arising under Federal Employees' Group Life Insurance Act, which contains a preemption provision similar to FEHBA's); *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (AHIP participated as *amici* in

ERISA case); *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356 (2006) (same).

This case is of significant importance to *amici*, whose members contract with the Office of Personnel Management under 5 U.S.C. § 8902 to offer a significant percentage of all FEHBA health plans offered across the United States. As explained below, the Missouri Supreme Court's rulings on preemption, and the concurrence's reasoning concerning the Supremacy Clause, could make the design and administration of FEHBA health plans exceedingly complex and expensive for carriers, federal employees, and taxpayers, who shoulder the burden of those costs each year.

SUMMARY OF ARGUMENT

Congress enacted the Federal Employee Health Benefits Act to ensure that federal employees have access to affordable, high quality healthcare plans offering uniform benefits and rates regardless of where the employee happens to live and work. To make the Act's promise a reality, Congress charged the Office of Personnel Management ("OPM") with regulating the terms, conditions, and administration of FEHBA plans.

OPM engages in detailed oversight and regulation of every aspect of the program, demonstrating both the importance of the program to the federal government and its careful consideration of the impact of various provisions on enrollees. OPM has issued regulations and guidance governing a wide range of plan activities,

including what and how they communicate about plan provisions with enrollees. Among other things, the federal government: specifies benefits that FEHBA plans must offer; drafts the standard form contract that carriers must execute when agreeing to participate in the FEHBA program; and approves each and every page of the plan benefit brochures FEHBA enrollees receive. This includes the subrogation language at issue in this case, which, like all terms of FEHBA contracts or benefits brochures, is authorized by federal statute and/or regulation, and has been reviewed and approved by the federal government, through OPM.

The Missouri Supreme Court's holding, if affirmed, would undermine Congress and OPM's goals by adding significant cost and complexity to the FEHBA Program and paving the way for the cross-state subsidization of health benefits (which Congress expressly sought to avoid). OPM and FEHBA carriers would be required to adjust organizational structures, and possibly even re-price premiums, to account for the uncertainty and administrative burden that would result from carriers' need to comply with state laws regulating reimbursement and/or subrogation. The increased complexity, and therefore cost, are compounded by the range of such laws, which include not only outright prohibitions on subrogation (as in Missouri) but more subtle distinctions, such as: limitations on the specific kinds of benefits that may be subject to reimbursement and/or subrogation; the "make-whole" doctrine; and the "common-fund" rule.

Affirming the decision below also would put FEHBA carriers to an untenable choice: comply with their contractual obligations to pursue subrogation recoveries or risk lawsuits alleging improper subrogation activities in states that do not permit it in some or all circumstances. As shown by the class action complaint filed in this very case, which seeks compensatory and punitive damages, that kind of litigation can be protracted and expensive.

The reasoning of the concurrence below threatens to compound exponentially the problems portended by the majority's decision. If the Supremacy Clause cannot accomplish preemption in these circumstances, then a whole range of state substantive and procedural rules that Congress clearly meant to override would apply to FEHBA plans. These requirements range from minimum-benefits rules mandating that certain types of care be covered by all policies sold within a state, to detailed claims-handling requirements, to rules for contesting benefits determinations. Compliance with all such state requirements – which often conflict with one another – would add substantial cost and complexity to the administration of FEHBA plans and endanger the viability of the multi-state and national plans Congress sought to create for the federal workforce.

This Court should reverse the judgment below.

ARGUMENT

I. Congress And OPM Exercise Substantial Control Over The Content Of FEHBA Contracts And Benefits Brochures, Including Subrogation Clauses, Lending Support To The Argument That FEHBA Preempts State Anti-Subrogation Laws.

In choosing to go into direct conflict with the U.S. Court of Appeals for the Tenth Circuit, *see Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090 (10th Cir. 2015), as well as the Arizona Court of Appeals, *see Kobold v. Aetna Life Ins. Co.*, 370 P.3d 128 (Az. Ct. App. 2016), the Missouri Supreme Court expressed great reluctance to "permit[] contract terms to preempt state law." Pet. App. 12a. This reasoning fundamentally misunderstands the "contracts" at issue here.

FEHBA plans are not mere private health insurance contracts negotiated between insurance companies and their customers. Rather, they are federal plans whose every detail is controlled by the Office of Personnel Management ("OPM"). This is the way it *must* be for OPM to achieve Congress' express goal of "offer[ing] uniform benefits and rates to [FEHB] enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997).

1. Congress enacted FEHBA to establish "a comprehensive program of health insurance for federal employees." *Empire HealthChoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 682 (2006). Under the Act, the Office of Personnel Management contracts with

private insurance companies, known as FEHBA "carriers," to "offer federal employees an array of health-care plans." *Id.* Over 8 million federal employees, retirees, and their dependents receive coverage through the FEHB Program each year. *See Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29203, 29203 (May 21, 2015); *see also* Kirstin B. Blom and Ada S. Cornell, Congressional Research Service, *Federal Employees Health Benefits (FEHB) Program: An Overview*, at 1 (Feb. 3, 2016) ("CRS Report").[2]

FEHBA plans are funded by premiums paid by the federal government and plan enrollees. The lion's share of these premiums – generally 72% – is paid by the federal government, with the remainder coming from enrollees. *See* 5 U.S.C. § 8906(b)(1). The premiums are paid into a special fund in the U.S. Treasury, established by Congress and administered by OPM, known as the Employee Health Benefits Fund ("Treasury Fund"). *Id.* § 8909. Any money left in the Treasury Fund at the end of the year is used, in OPM's discretion, to reduce premium rates or to "increase the benefits provided by[] the plan." 5 U.S.C. § 8909(b); *see also* 5 C.F.R. § 890.503(c)(2).

FEHBA plans come in two basic varieties: "community-rated" and "experience-rated." A community-rated plan, like the one at issue here, receives a "per member per month capitation rate" for each member

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[2] Available at https://fas.org/sgp/crs/misc/R43922.pdf (last visited Dec. 18, 2016).

enrolled in the plan. 42 C.F.R. § 1602.170-2. Community-rated carriers receive these payments up front from the Treasury Fund and use those premiums to pay claims consistent with OPM guidelines. *Id.* § 1632.170(a). Community-rated plans tend to cover specific metropolitan areas; however, as shown by the plan at issue here, they often operate across state lines.

Experience-rated plans, by contrast, receive premiums based on "actual paid claims" (subject to certain adjustments). 48 C.F.R. § 1602.170-7. Experience-rated carriers may access these funds on a "letter of credit" basis, drawing down the funds necessary to pay claims made from the Treasury Fund set up to administer the FEHB Program. *Id.* § 1632.170(b). The carriers' profit comes not from premiums charged or the efficient management of healthcare utilization, but from a "service charge" they negotiate with OPM. *See* 48 C.F.R. § 1615.404-4. Experience-rated plans are generally open to federal employees nationwide.

A "significant proportion of" the FEHB Program's more than 8 million enrollees "are covered through nationwide fee-for-service plans with uniform rates," 80 Fed. Reg. at 29203, which are experience-rated, CRS Report at 9 n.48. Community-rated plans, like the one at issue in this case, cover the remainder of the FEHB Program's enrollees and account for the rest of its expenses.

2. OPM negotiates the terms of the federal health benefit contracts with all FEHBA carriers. 5 U.S.C. § 8902(a). Congress specified the types of coverage that FEHBA plans must offer. 5 U.S.C. § 8904. It further directed OPM to "prescribe reasonable minimum standards for health benefits plans" offered under FEHBA. *Id.* § 8902(e); *see also* 42 C.F.R. § 890.201 (setting forth those standards). Congress also specified that the rates charged by FEHBA carriers "shall reasonably and equitably reflect the cost of the benefits provided," *id.* § 8902(i), which necessarily implicates the ability of carriers to reduce those costs through subrogation and/or reimbursement.

As with other government insurance programs administered by private companies (such as the National Flood Insurance Program), OPM created a standard form contract it uses when contracting with FEHBA carriers. *See, e.g.*, FEHB 2012 Standard Contract for Community-Rated Health Maintenance Organizations (Jan. 27, 2012);[3] FEHB 2012 Standard Contract for Experience-Rated Health Maintenance Organizations (Jan. 1, 2012).[4] Each year, OPM also issues proposed amendments to those standard contracts, showing the changes OPM has made from the prior year. *See, e.g.*, Proposed Changes to Standard 2016 Community-Rated HMO Health Benefits

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[3] Available at http://www.opm.gov/healthcare-insurance/healthcare/carriers/community-rated.doc (last visited Dec. 18, 2016).

[4] Available at http://www.opm.gov/healthcare-insurance/healthcare/carriers/experience-rated.doc (last visited Dec. 18, 2016).

Contract;[5] Proposed Changes to Standard 2016 Experience-Rated HMO Health Benefits Contract.[6]

Congress also required OPM to "make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to [OPM] after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans. . . ." 5 U.S.C. § 8907(a). Congress similarly required that each person who enrolls in a FEHBA plan receives "an appropriate document setting forth or summarizing the – (1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder; (2) procedure for obtaining benefits; and (3) principal provisions of the plan affecting the enrollee and any eligible family members." *Id.* § 8907(b). OPM meets this requirement by requiring carriers to send each enrollee a document commonly known as the FEHB "benefits brochure."

However, it is OPM, and not the FEHBA carriers, that ultimately is responsible for the content of these brochures. 42 C.F.R. § 1603.7001. That brochure also serves another function required by Congress; it constitutes the contractual "detailed statement of benefits offered," including "such maximums, limitations,

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[5] Available at https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-17a1.pdf (last visited Dec. 18, 2016).

[6] Available at https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-17a2b.pdf (last visited Dec. 18, 2016).

exclusions, and other definitions of benefits as [OPM] considers necessary or desirable." 5 U.S.C. § 8902(d); *see also* J.A. 80, 113 (contract provisions requiring Petitioner to provide all services specified in benefits brochure attached to contract). The brochure is typically attached to each contract between the FEHBA carrier and OPM. *See* J.A. 235 (brochure attached to contract as Appendix A); *see also McVeigh*, 547 U.S. at 684 (noting benefits brochure is appended to OPM-carrier contract).[7]

These statutes and regulations ensure that OPM exercises nearly complete control over the contents of its contracts with carriers, including the benefits brochure that describes enrollees' rights and responsibilities under the FEHBA plan. Thus, no carrier could insert subrogation language in its brochure unless that is precisely what the federal government intended for it to do. With Congress having explicitly given OPM authority over the contract terms (including the benefits brochure), and with Congress intending that those

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[7] OPM uses a multi-step, months-long process to ensure uniformity in the benefits brochures that go out to FEHBA enrollees. That process starts with OPM sending the carrier its latest "brochure handbook"; proceeds with OPM giving carriers access to an online brochure-creation tool and training them how to use it; continues with OPM reviewing and approving any proposed deviations from the standard brochure language; and ends with OPM telling the carrier how many brochures are needed and may be charged to the FEHBA contract. *See, e.g.*, FEHB Program Carrier Letter No. 2015-03(b), Attachment II ("Preparing Your 2016 Brochure"), available at https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-03b.pdf (last visited December 12, 2016).

terms – not state insurance laws – govern issues relating to coverage or benefits, there is no place for the Missouri Supreme Court's restrictive reading of FEHBA's preemption provision. That is particularly true here, where the subrogation activities OPM requires save federal employees and taxpayers significant money each year, as we address next.

II. FEHBA Reimbursement And Subrogation Saves The Federal Treasury Substantial Amounts Of Money Each Year.

OPM requires FEHBA carriers to pursue subrogation activities. As noted above, OPM publishes standard contracts for both experience-rated and community-rated carriers. The relevant subrogation section of each of those Standard Contracts requires all FEHBA carriers to "subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members," according to a series of rules that apply depending on whether the state(s) in which the carrier is doing business permit subrogation. *See* Standard Contract for Community-Rated HMOs, *supra* n.3, § 2.5; Standard Contract for Experience-Rated HMOs, *supra* n.4, § 2.5. Of relevance to this case, "[t]he Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA)." *Id.* § 2.5(a)(2). The subrogation clause of the

OPM-Carrier contract at issue in this case contains this very same language. *See* Pet. App. 147a.[8]

FEHB benefits brochures typically contain subrogation and/or reimbursement language required by these federal regulations and contracts. For example, the benefits brochure for the FEHBA plan at issue in this case, known as the Group Health Plan, states: "If you do not seek damages you must let us try. This is called subrogation. If you need more information, contact us for subrogation procedures." Pet. App. 147a.

As explained below, the Government has a compelling reason to require Carriers to pursue these recoveries: FEHBA reimbursement and subrogation saves the FEHBA Program, and thus the U.S. Treasury, substantial amounts of money each year.

Both community-rated and experience-rated carriers save the government money by pursuing subrogation, albeit in different ways. Experience-rated plans, who insure the largest percentage of federal employees, must return all reimbursement and subrogation recoveries (net of the expenses in obtaining the recoveries) directly to the Treasury Fund set up to finance the FEHB Program. *See* 48 C.F.R. §§ 31.201-5, 1631.201-70(a) & (g), 1652.216-71(b)(2)(i); *see also*

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[8] OPM later promulgated a new regulation requiring that all FEHBA contracts contain such a provision: "All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section." 5 C.F.R. § 890.106(a) (emphasis added).

McVeigh, 547 U.S. at 685 ("Pursuant to the OPM-BCBSA master contract, reimbursements obtained by the carrier must be returned to the Treasury Fund."). Thus, subrogation by experience-rated carriers saves the federal government money on an almost dollar-for-dollar basis.

Community-rated carriers also save money for the Treasury Fund when they pursue subrogation activities. As the United States explained in the *amicus* brief it filed in the court below, "[s]ubrogation recoveries by community-rated carriers also lower subscription charges for enrollees and the federal government." Pet. App. 170a. "The premiums that community-rated carriers charge generally depend on the expected cost of providing benefits." Pet. App. 171a. "Subrogation recoveries by community-rated carriers tend to reduce those expected costs, and thus the premiums," *id.* – over 70% of which are paid by the federal government. Federal employees benefit as well, of course, as they pay the remainder of these premium costs.

The total effect of these subrogation recoveries is substantial. OPM estimates that reimbursement and subrogation recoveries save the FEHB Program – and the enrollees and taxpayers who fund it – over $125 million per year. *See* Pet. App. 151a.

III. Exempting Anti-Subrogation Laws From Federal Preemption Would Add Substantial Complexity, Uncertainty, And Cost To The Administration Of FEHBA Plans.

Congress enacted FEHBA to create a uniform, national program for federal employee health benefits, with plans "offer[ing] uniform benefits and rates to [FEHB] enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997). For that system to work, federal – and not state – law must govern every aspect of FEHBA benefit administration.

A FEHBA program where states set the ground rules with respect to reimbursement and subrogation would lead to a system that is neither uniform nor national. "Disuniform application of FEHB contract terms as they apply to enrollees in different states is administratively burdensome, gives rise to uncertainty and litigation, and results in treating enrollees differently, although enrolled in the same plan and paying the same premiums." *Federal Employees Health Benefits Program; Subrogation and Reimbursement*, 80 Fed. Reg. 931, 932 (Jan. 7, 2015). That is precisely what would happen if this Court affirms the decision below.

1. State reimbursement and subrogation laws are varied and complicated. *See generally* AFHO State Survey of Reimbursement Laws in The Health Insurance Context ("AFHO State Survey") (Feb. 2014).[9] Several states, including Missouri, generally prohibit

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[9] Available at http://crmerlaw.com/PDFs/Feb2014%20FHOState SurveyWithMap.pdf (last visited Dec. 18, 2016).

reimbursement and/or subrogation altogether. *See, e.g.*, Ariz. Rev. Stat. § 12-565; Conn. Gen. Stat. Ann. § 52-225a; N.J. Stat. Ann. § 2A:15-97; N.Y. Gen. Oblig. Law § 5-335(a); 11 N.C. Admin. Code § 12.0319; Va. Stat. § 38.2-3405; *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 419 (Mo. Ct. App. 1965); Kan. Admin. Regs. § 40-1-20.

Other states take a more nuanced approach. Michigan, for example, generally allows subrogation if a health insurance plan contains a reimbursement or subrogation provision. *See Foremost Life Ins. Co. v. Waters*, 329 N.W.2d 688, 689 (Mich. 1982). However, it prohibits subrogation in automobile accidents governed by its No-Fault Act, *Great Lakes Am. Life Ins. Co. v. Citizens Ins. Co.*, 479 N.W.2d 20, 21 (Mich. Ct. App. 1991).

The patchwork of state reimbursement and subrogation laws is not limited to the question of whether subrogation is allowed and/or in what contexts. States also employ numerous legal and equitable doctrines that can prevent a health insurer from obtaining reimbursement even in jurisdictions where seeking reimbursement and/or subrogation are permissible. For example, many states apply a version of the "make-whole" doctrine. *See generally* AFHO State Survey, *supra* n.9, at 1 (map identifying approximately 20 "make-whole" states). Under this doctrine, an insurer may not subrogate until its insured receives full compensation for his or her loss. *See, e.g.*, *Dufour v. Progressive Classic Ins. Co.*, 881 N.W.2d 678, 683 (Wis. 2016). But, of course, states do not entirely agree on what it means to be "made whole." Some, such as Wisconsin, hold that

an insured is made whole only when the insured is compensated for *all* of his or her injuries, *see Rimes v. State Farm Mutual Auto Insurance Co.*, 316 N.W.2d 348, 355 (Wis. 1982). Other states, such as Iowa, hold that carriers are allowed to subrogate when the insured is compensated for the element of damages that the carrier has already paid, *see Ludwig v. Farm Bureau Mutual Insurance Co.*, 393 N.W.2d 143, 145 (Iowa 1986). Further, many states will apply the make-whole doctrine even when the insurance plan contains language that expressly rejects it.

Many states also apply the "common-fund" rule in reimbursement and/or subrogation cases. *See generally* AFHO State Survey, *supra* n.9, at 1 (map identifying nearly 40 "common-fund" states). Under this rule, "a litigant or lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as a whole." *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1545 (2013) (internal quotation marks and citation omitted). In practice, this rule requires FEHBA carriers that do not actively participate in litigation to reduce their reimbursement and/or subrogation demands to absorb a portion of the plaintiff's attorney's fees. Like the "make-whole" doctrine, the rule therefore operates to limit what FEHBA carriers might recover even in states where subrogation and/or reimbursement is available.

2. Against this backdrop, it is easy to see how the Missouri Supreme Court's ruling with respect to subrogation would undercut Congress' goal of having a single, nationwide system for federal employee health

benefits. The effect on those paying for such plans – the federal government and enrollees – is amplified because of the resulting, significant increase in the administrative difficulty, burden, and expense of administering FEHBA plans in an environment of fifty separate approaches to subrogation. These increased costs to the government and to individual federal employees is felt both directly (through lost recoveries that would otherwise benefit the Treasury Fund) and indirectly (through higher administrative costs that make the program more expensive to administer).

A few hypothetical scenarios drive home how quickly uniformity is lost, and the government and federal employees are harmed, when fifty approaches to subrogation are substituted for OPM's. Although these examples are drawn from specific plans that cover particular regional markets, the problems are equally – if not more – acute for those plans available to federal employees nationwide; if the decision below were affirmed, they would be required to account for similar nuances in state subrogation and reimbursement across all 50 states.

Scenario 1: St. Louis. In the absence of preemption, a federal employee's choice of where to live within a given metropolitan area could determine whether reimbursement and/or subrogation are even available to the FEHBA carrier. Imagine that Jack and Jill are two federal employees working in the St. Louis Field Office of the FBI. Jack lives in suburban St. Louis, just west of downtown. Jill, on the other hand, lives just across the river in southern Illinois. Both elected to enroll in

the same plan offered to federal employees living in the greater St. Louis area (which extends into Illinois) – like the Coventry Group Health Plan at issue here, *see* Pet. App. 145a (noting service area). As co-workers enrolled in the same plan, they pay the same premium for their coverage.

Now imagine that one day, Jack and Jill each get into an accident as soon as they have pulled out of their driveways on the way to work. Because each sustained the very same injuries, the Coventry paid identical sums (say, $5,000) for care related to each accident. However, the Coventry's rights would be different in each case, by virtue of the fact that Jack lives in and was injured in Missouri, whereas Jill lives in and was injured in Illinois.

Coventry would be able to bring suit in Illinois to recover from the liable third party for Jill's injury there, or to seek reimbursement from any settlement proceeds she obtains. However, under the reasoning of the court below, Coventry could *not* pursue recovery for Jack's identical injuries in Missouri. Hence, two participants in the same plan paying the same premium will, in effect, receive different benefits simply because they lived in different states. This is antithetical to the purposes of the FEHB Program. *See* 80 Fed. Reg. at 932 ("Congress enacted the preemption provision to avoid such disparities, and to enhance the ability of the Federal Government to offer its employees a program of health benefits governed by a uniform set of legal rules.").

Scenario 2: Road Trip. An employee's state of residence is not the only factor that would undermine the uniformity of plan benefits under the ruling below. Imagine that Jack and Jill were traveling together on a road trip to Chicago when they got in an accident. If that accident happened in Missouri just after they left the office, Coventry still would not be entitled to reimbursement and/or subrogation for Jack's injuries.

In Jill's case, however, the issue is not as cut-and-dried. Does the law of Missouri (the *lex loci delicti*) or the law of Illinois (the *lex loci contractus*) apply? The same questions would remain, though in reverse, if the accident happened after Jack and Jill crossed over the Mississippi River into Illinois. In either instance, Coventry would likely be required to conduct a detailed investigation of the facts of the case, and possibly even to litigate its rights to recover the expenses it advanced on Jack and/or Jill's behalf.

Moreover, because Illinois applies both a version of the make-whole doctrine and the common-fund rule, *see* 770 Ill. Comp. Stat. 23/50-2; *Bishop v. Burgard*, 764 N.E.2d 24 (Ill. 2002), Coventry will have additional hurdles to clear even if it is able to recover in Illinois for the injuries one or both sustained there. This, too, exacerbates the differences between the benefits that Jack and Jill are entitled to keep under the very same plan.

Scenario 3: Washington, D.C. These variations in state law become more problematic for FEHBA plans as they expand to cover more jurisdictions. For

example, there are numerous plans in the Washington, D.C. area that cover federal employees and annuitants residing in the District, Maryland, and Virginia (such as Aetna's Open Access HMO[10]).Under the court's decision below, these enrollees' choices about where to reside within the Beltway has meaningful consequences for carriers and the enrollees alike.

Imagine that Jack and Jill are selected for positions in the FBI's headquarters in Washington, D.C. Jack moves to Alexandria, VA, while Jill chooses to live in the District. Both elect the same Aetna plan discussed above and pay the same premiums. If they each are injured near their homes, Virginia law would prohibit Aetna from seeking subrogation or reimbursement for Jack's injuries. *See* Va. Stat. § 38.2-3405. The District of Columbia, by contrast, would permit that kind of recovery. *See Murrell v. Criterion Ins. Co.*, 551 A.2d 95, 96 (D.C. 1988); *see also* D.C. Code § 31-3407(a)(2)(P) (allowing HMOs to provide for subrogation in their contracts).

It is *not* clear, however, whether Virginia law would bar Aetna from subrogating if Jill were injured after crossing the Potomac on her way to visit Jack in Alexandria. Virginia's anti-subrogation provision only extends to insurance contracts "delivered or issued for delivery or providing for payment of benefits to or on behalf of persons residing in or employed in this

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[10] The Benefits Brochure for that plan is available at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2017/brochures/73-052.pdf (last visited Dec. 18, 2016).

Commonwealth." Va. Code Ann. § 38.2-3405. Because Jill does not live or work in Virginia, that statute arguably would allow Aetna to enforce its subrogation clause in connection with injuries sustained by a D.C. resident. There is no case law directly answering this question, however, meaning that Aetna could have to undertake (or risk) expensive litigation to find out whether it could recover in those circumstances.

Maryland likely would allow subrogation and/or reimbursement as well, if Jill had happened to move to Silver Spring instead of the District. *See, e.g.*, Md. Code Ann., Health-Gen. § 19-713.1(d) (allowing HMOs to provide for subrogation in their contracts). However, Maryland would *not* permit the carrier to be subrogated to any PIP benefits. *See id.* § 19-713.1(e).

The consequences of Jill's decision to move to Maryland instead of D.C. extend beyond the mere availability of subrogation in the first instance. As in the St. Louis example discussed above, this choice also implicates issues related to the make-whole doctrine. Unlike the District of Columbia, *Pac. Coast Dist., Marine Eng'rs' Ben. Ass'n v. Travelers Cas. & Sur. Co.*, 782 A.2d 269 (D.C. 2001), Maryland does not apply the make-whole doctrine, *Stancil v. Erie Ins. Co.*, 740 A.2d 46, 46 (Md. Ct. Spec. App. 1999). Thus, whether the carrier is entitled to subrogate at all could depend on how much Jill recovers from the liable third party, relative to the injuries she sustained.

Scenario 4: National Plans. These discrete hypotheticals, based on plans covering specific metropolitan areas, illustrate the complexity that would result from affirming the decision below. Multi-state and national plans that offer uniform benefits and rates to enrollees across a number of jurisdictions would face even greater challenges. As discussed above, each state has a different permutation of anti-subrogation rules, the make-whole doctrine, and the common-fund rule. *See generally* AFHO State Survey, *supra* n.9. And as described below, the burdens of administering a plan against that backdrop will make it difficult – if not impossible – to fulfill Congress' purposes in enacting the FEHB Program.

3. These hypotheticals illustrate the obvious: the FEHB Program cannot exist as it does now, with national and multi-state plans offering uniform rates and benefits to all enrollees, if state subrogation laws override OPM's regulations and contract provisions.

The consequences of the Missouri Supreme Court's holding would be particularly acute for the nationwide and multi-state FEHBA plans. Those plans – which insure a significant percentage of all FEHBA enrollees – would be faced with two distinct kinds of challenges, both of which are likely to reduce options and increase costs for federal employees and taxpayers.

First, these multi-state plans will be required to structure their systems and train their employees to take account of the patchwork of state subrogation and reimbursement laws. Among other things, plans

will need to constantly monitor: prohibitions on subrogation and/or reimbursement; limitations on the kinds of coverage for which carriers may pursue subrogation and/or reimbursement; legal and equitable "make-whole" rules that can prohibit recovery in certain cases; and common-fund rules that work to reduce the amounts to which the carrier is entitled, even in states where recovery is permitted.

Moreover, because OPM continues to require carriers to pursue subrogation, *see* 5 C.F.R. § 890.106(a), carriers will have no choice but to conduct expensive and time-consuming investigations of each case to determine where reimbursement and/or subrogation is available under these varying state rules. If there is any question about which state's laws apply in a given circumstance, carriers may need to consult legal counsel on choice-of-law questions in routine subrogation investigations. After all, the costs of getting that question wrong can be immense: an expensive and time consuming class action alleging improper subrogation activities, as this case itself illustrates. Moreover, as is also illustrated by this case (*see* J.A. 64, 74), such litigation is likely to include claims for punitive damages and/or other damages multipliers available under state law. In a world where FEHBA does not preempt anti-subrogation laws, the prospect of enhanced damages can only serve to deter plans from taking steps in an uncertain legal landscape to comply with their contractual obligations to OPM.

Second, OPM and multi-state carriers would have to grapple with the difficult question of accurately setting premiums when operating across a patchwork of states with widely varying subrogation and/or reimbursement rules. Premiums for national plans, which tend to be experience-rated plans, are to be determined using a "cost analysis" methodology. *See* 42 C.F.R. § 1615.402(b). Calculating that prospective "cost" will be extremely difficult where OPM and the carriers have to price into their plans a significant amount of uncertainty concerning the carriers' ability to pursue reimbursement and/or subrogation in many of the states where they operate. The additional costs, of course, are borne by the federal government and by federal employees in the form of higher premiums.

All of this will harm federal employees and the federal government, because it substantially increases the complexity (and thus cost) of administering FEHBA plans, particularly nationwide plans. That increased complexity, in turn, could drive premiums higher – especially when coupled with the loss of subrogation revenue that would otherwise flow back to the Treasury Fund. Federal taxpayers will bear the brunt of any premium increase – 72%, *see* 5 U.S.C. § 8906(b)(1) – with FEHBA enrollees picking up the rest.

Similar harms will be felt by federal employees enrolled in regional and multi-state HMOs as well, like aforementioned plans serving the greater St. Louis and Washington, D.C. areas. Such plans, too, will need to design complex systems to conduct recovery

activities within the bounds of the myriad subtle distinctions drawn by the jurisdictions they cover. They also will need to work with OPM to set premiums that account for that complexity, as well as the variability in state subrogation and reimbursement laws.

4. In the end, consumers may find themselves with fewer health plan choices. Given the logistical and operational challenges of designing a FEHBA plan that complies with multiple states' subrogation laws – let alone 50 states' subrogation laws – one likely effect of affirming the Missouri Supreme Court's ruling would be to encourage carriers to offer more state-specific plans instead of the national and multi-state plans Congress chose to promote. After all, in the hypotheticals discussed above, it is likely that residents of Illinois, D.C., and Maryland would bristle at the thought of paying higher premiums to be in a pool with their colleagues living in Missouri and Virginia, where carriers now will have to absorb greater losses. Those consumers may opt to join cheaper, single-state plans based in jurisdictions that allow reimbursement and subrogation, leaving their federal counterparts in neighboring jurisdictions with higher cost plans and/or plans that offer different benefits.

That result would unquestionably frustrate Congress' aim in enacting FEHBA. Single-state plans composed of only federal employees (and their dependents) are unlikely to have sufficient scale to offer the same kind of benefits and rates that multi-state and national FEHBA plans can. And, it goes without saying, those plans will not offer the kind of multi-state

uniform benefits Congress intended to provide the federal workforce.

IV. The Missouri Supreme Court's Alternative Holding That FEHBA's Preemption Clause Violates The Supremacy Clause Has the Potential to Make FEHBA Plan Administration Untenable.

Six concurring judges also concluded that Section 8902(m)(1)'s "attempt to give preclusive effect to the provisions of a contract between the federal government and a private party is not a valid application of the Supremacy Clause in Article VI of the U.S. Constitution." Pet. App. 14a. If correct, this holding would create tremendous uncertainty and complexity for FEHBA carriers well beyond the reimbursement and/or subrogation rules noted above. A FEHBA program where states set the ground rules is likely to be untenable.

State regulation of health insurance takes many different forms. Many state regulations prescribe the minimum benefits health insurers must cover under contracts sold within their borders. If these state laws were not preempted, then FEHBA carriers would be left with two choices: either negotiate separate plans for federal employees in each state or negotiate a nationwide plan that satisfies the mandated-benefit laws of all 50 states. Neither option is desirable and neither serves the purposes of the FEHB Program.

Having to negotiate state-by-state contracts would prevent carriers from being able to offer uniform benefits to all enrollees in a given plan regardless of where they live. And the significant administrative costs associated with negotiating multiple contracts on a state-by-state basis could result in higher premium rates for all enrollees in those plans, as well as for the federal government, which pays the majority of those premium costs.

Negotiating a single nationwide plan that covered all of the various benefits required by the 50 states would be no better. That would leave control of federal employee health benefits to 50 individual state regulators, in direct contravention of Congress' goal of making federal employee benefits a matter of federal law. Moreover, a 50-state plan covering the furthest reaches of state requirements in each state would force plan enrollees in most states to cross-subsidize benefits for plan enrollees in whichever state has the most stringent mandated-benefit laws.

The effects of the concurrence's reasoning would not be limited to mandated-benefit requirements, however. There are myriad other requirements that states impose on health plans that "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). States regulate numerous other aspects of health insurance, including: which family members must be covered; the age limits for covered family members; extension of coverage; and informational material that

must be provided to plan enrollees, including the specific language that must be used in plan brochures.

The variation and conflict among state laws also extends to procedural requirements imposed on insurers. States regulate when the claim must be acknowledged by the insurance provider; when the insurance provider must begin its investigation; when the insurance provider must make its determination; when, and the manner in which, the plan member must be notified of a delay in the payment of the claim; when a claim must be finally paid out; and the interest that must be paid in the event the claim is delayed. To make matters worse, states' time frames often conflict with one another, making carriers' compliance in the absence of federal preemption more expensive and burdensome.

To date, courts have found such laws to be preempted by FEHBA's preemption clause. *See, e.g.*, *Health Care Service Corp. v. Methodist Hospitals of Dallas*, 814 F.3d 242, 253-55 (5th Cir. 2016) (FEHBA preempts Texas law regulating time frame in which health insurers must make coverage determinations and pay providers); *Zipperer v. Premera Blue Cross Blue Shield of Alaska*, 2016 U.S. Dist. LEXIS 109531, *11-18 (D. Alaska Aug. 16, 2016) (FEHBA preempts Alaska "prompt pay" statute). If this Court were to hold that FEHBA's preemption clause is unconstitutional, however, such laws would presumably apply to all FEHBA carriers.

The need to comply with all of these myriad substantive and procedural requirements would create an especially heavy burden for multi-state and national FEHBA plans that operate across many jurisdictions. Moreover, it would directly conflict with the will of Congress, which sought to avoid this very state of affairs. *See McVeigh*, 547 U.S. at 686 (noting that Congress enacted the FEHBA preemption provision to override "'State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage'" (quoting H.R. Rep. No. 95-282, pp. 4-5 (1977)).

When Congress enacted the FEHBA preemption clause in 1977, it noted that "States are becoming more active in establishing and enforcing health insurance requirements which conflict with provisions of the FEHB contracts." H.R. Rep. No. 95-282, at 4 (1977). "These conflicting requirements can be expected to result in: Increased premium costs to both the Government and enrollees[] and [a] lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some states paying a premium based, in part, on the cost of benefits provided only to enrollees in other states." *Id.* This would directly conflict with "One of the most beneficial features of our FEHB plans" – "the requirement that they provide the same uniform benefits for the same premium for all enrollees in a plan." H.R. Rep. No. 94-1211, at 6 (1976).

Like the court's subrogation holding, the consequences of the concurrence's reasoning are easy to discern: disparate benefits across state lines; more complex plan administration that leads to higher costs for taxpayers and enrollees; and fewer national and multi-state plans. This Court should emphatically reject reasoning that would undermine these core goals of the FEHB Program.

CONCLUSION

For the foregoing reasons, the Court should reverse the judgment of the Missouri Supreme Court.

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RECORD AND BRIEFS

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COVENTRY HEALTH CARE OF MISSOURI, INC.,
Petitioner,

v.

JODIE NEVILS,
Respondent.

ON WRIT OF CERTIORARI
TO THE SUPREME COURT OF MISSOURI

BRIEF FOR THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* SUPPORTING PETITIONER

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INTEREST OF *AMICUS CURIAE*

The Chamber of Commerce of the United States of America is the world's largest business federation. It represents 300,000 direct members and indirectly represents the interests of more than three million companies and professional organizations of every size, in every economic sector, from every region of the country. One important function of the Chamber is to represent the interests of its members in matters before Congress, the executive branch, and the courts. To that end, the Chamber regularly files *amicus* briefs in cases that raise issues of concern to the nation's business community.[1]

This is such a case. The Chamber's membership includes businesses that are subject in varying degrees to a wide range of federal regulatory schemes that contain provisions expressly preempting state and local laws. As a result, the Chamber is well suited to offer a broader perspective on preemption and keenly interested in ensuring that the regulatory environment in which its members operate is a consistent one. The Chamber has filed *amicus* briefs in prior preemption cases, including *Puerto Rico v. Franklin California Tax-Free Trust*, 136 S. Ct. 1938 (2016); *National Meat Association v. Harris*, 132 S. Ct. 965 (2012); *AT&T Mobility LLC v. Concepcion*,

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[1] Pursuant to Rule 37.6, *amicus* affirms that no counsel for a party authored this brief in whole or in part, and that no party, counsel for a party, or any person other than *amicus*, its members, or its counsel made a monetary contribution intended to fund the preparation or submission of the brief. All parties have consented to the filing of this brief.

563 U.S. 333 (2011), *Williamson v. Mazda Motor of America, Inc.*, 562 U.S. 323 (2011), *Bruesewitz v. Wyeth LLC*, 562 U.S. 223 (2011), *Wyeth v. Levine*, 555 U.S. 555 (2009), *Altria Group, Inc. v. Good*, 555 U.S. 70 (2008), *Riegel v. Medtronic, Inc.*, 552 U.S. 312 (2008), *Geier v. American Honda Motor Co.*, 529 U.S. 861 (2000), and *United States v. Locke*, 529 U.S. 89 (2000), and is well-situated to address the issues of preemption raised here.

The Chamber has a particular interest in this case, which concerns the "presumption against preemption" that members of this Court have sometimes invoked. By making it more difficult for Congress to enact nationwide regulatory schemes, such a presumption—particularly if applied as strenuously as in the decision below—threatens to breed patchwork legal regimes that would burden the ability of multistate businesses, many of which are members of the Chamber, to operate efficiently and effectively.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case concerns the preemptive effect of the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, which includes an express preemption provision:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

Respondent Jodie Nevils is a federal employee who participates in a federal health insurance plan administered by Coventry pursuant to a contract governed by FEHBA. Pet. App. 45a. After Nevils was injured in a car accident, Coventry paid for his medical expenses pursuant to the FEHBA plan. *Id.* Nevils obtained a tort settlement from the third party who had caused his injuries, and Coventry sought subrogation or reimbursement out of the settlement proceeds as required under the terms of the FEHBA plan contract. *Id.*; *see id.* at 129a-30a.

Nevils paid the subrogation claim, but then filed this putative class action against Coventry, alleging that Coventry's pursuit of subrogation violated Missouri's common-law prohibition against subrogation claims. *Id.* at 45a. Coventry argued that FEHBA preempted application of that doctrine with respect to a FEHBA contract, but the Missouri Supreme Court twice rejected that defense. The court first held in 2014 that § 8902(m)(1) is ambiguous as to whether state anti-subrogation rules are preempted because subrogation does not clearly "relate to ... coverage or benefits," and that a presumption against preemption required resolving such an ambiguity against Coventry. *Id.* at 47a-54a. After this Court vacated that judgment and remanded for further consideration in light of a new regulation promulgated by the Office of Personnel Management ("OPM"), 135 S. Ct. 2886 (2015), the Missouri Supreme Court adhered to its prior view of the statute. Pet. App. 2a, 7a, 13a. The Missouri court also declined to defer to OPM's regulatory interpretation of § 8902(m)(1), which codifies the agency's view that

the statute preempts state anti-subrogation laws. *Id.* at 4a-13a.[2]

The Missouri Supreme Court's holding is in error, as Petitioner correctly argues. The decision below relies on the premise that, when Congress enacts a provision expressly preempting state law, the statute should be presumed to preempt as little state law as linguistically possible. That presumption, however, should be rejected as a canon of construction. The text and history of the Supremacy Clause refute any notion that the Framers intended the courts to operate under any presumption against preemption: Federal law is to control "*notwithstanding*" anything to the contrary in state law, and Congress's enactments should not be given less (or more) preemptive effect than their words would permit under ordinary principles of statutory interpretation. Employing a narrowing interpretive presumption in preemption cases makes it more difficult for Congress to achieve its specific legislative ends, and encourages the development of conflicting state regulatory regimes that burden businesses and other multistate actors. And the presumption cannot be justified on federalism grounds, for the express text and clear purpose of the Supremacy Clause allow Con-

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[2] In an opinion concurring in the result, six of the Missouri Supreme Court's seven judges expressed the view that § 8902(m)(1) is invalid because it purportedly "give[s] preemptive effect to the provisions of a contract between the federal government and a private party," thereby exceeding the proper reach of the Supremacy Clause in their view. Pet. App. 13a-14a; *see id.* at 55a-72a.

gress to execute its constitutional authority without special concern about federalism. Where Congress has stated an intention to so exercise its authority, it should be taken at its word.

Without a presumption against preemption, the decision below cannot stand. Even if there may be multiple plausible readings, the single *best* interpretation of § 8902(m)(1) is that it expressly preempts state laws barring subrogation actions in cases arising out of FEHBA contracts. The Missouri Supreme Court did not contend otherwise, but ruled that it was required to presume that Congress had expressed no such intent. Stripping out the presumption eliminates the foundation for the Missouri court's interpretation of the statute.

ARGUMENT

I. WHERE CONGRESS EXPRESSLY STATES ITS INTENTION TO PREEMPT STATE LAW, NO PRESUMPTION AGAINST PREEMPTION APPLIES

A. The Court's occasional articulation of a presumption against preemption, *e.g.*, *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 518 (1992), has not been uncontroversial, *see, e.g.*, *id.* at 544 (Scalia, J., concurring in judgment in part and dissenting in part). And over the past two decades this Court's reliance on any such presumption "has waned in the express pre-emption context." *Altria Grp., Inc. v. Good*, 555 U.S. 70, 99 (2008) (Thomas, J., dissenting). That trend should continue, as there is neither need nor basis for a presumption against preemption when interpreting statutes that expressly reflect a Congressional judgment to preempt state law.

For instance, in *Riegel v. Medtronic, Inc.*, 552 U.S. 312 (2008), the Court omitted to mention the presumption in holding that the Medical Device Amendments to the Federal Food, Drug, and Cosmetic Act preempted the plaintiff's state-law claims—notwithstanding Justice Ginsburg's reliance on it in dissent, *id.* at 334 (Ginsburg, J., dissenting). Similarly in *Bruesewitz v. Wyeth LLC*, 562 U.S. 223 (2011), neither the majority opinion nor Justice Breyer's separate concurrence referenced the presumption in concluding that the Vaccine Act's express preemption provision barred state-law design-defect claims against vaccine manufacturers—again notwithstanding the dissent's invocation of the presumption to support a contrary conclusion, *id.* at 267 n.15 (Sotomayor, J., dissenting). Instead, the majority invoked only "the traditional tools of statutory interpretation" in order to give a contested term "its most plausible meaning" (not necessarily its *only* plausible meaning). *Id.* at 243.[3]

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[3] Numerous other recent decisions are in accord with this trend. *See, e.g.*, *Dan's City Used Cars, Inc. v. Pelkey*, 133 S. Ct. 1769, 1778 (2013) (unanimously interpreting text of Federal Aviation Administration Authorization Act as not preempting state-law causes of action without mentioning presumption); *Chamber of Commerce v. Whiting*, 563 U.S. 582 (2011) (omitting to mention presumption in interpreting Immigration Reform and Control Act's express preemption provision); *Cuomo v. Clearing House Ass'n, L.L.C.*, 557 U.S. 519, 534 (2009) (explicitly declining to "invoke[] the presumption against pre-emption" in interpreting express preemption clause); *see also Altria Group*, 555 U.S. at 99 (Thomas, J., dissenting) (collecting cases).

A plurality of the Court would have gone further in *PLIVA, Inc. v. Mensing*, 564 U.S. 604 (2011), explaining that, under the Supremacy Clause, "a court need look no further than the ordinary meanin[g] of federal law, and should not distort federal law to accommodate conflicting state law," *id.* at 623 (plurality opinion) (citation and internal quotation marks omitted). The plurality expressly criticized the presumption, stating that "courts should not strain to find ways to reconcile federal law with seemingly conflicting state law." *Id.* at 622.

The Court took further steps in this direction late last Term. In *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016), the Court explained that its jurisprudence on the scope of ERISA preemption rests on normal tools of statutory construction, without reference to any presumption that preemptive language should be read narrowly. *Id.* at 943. Instead, while noting that "'[p]re-emption claims turn on Congress's intent,'" the Court refused to apply any "presumption against pre-emption" in determining what that purpose was. *Id.* at 946 (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)). And the Court went still further in discounting the presumption in *Puerto Rico v. Franklin California Tax-Free Trust*, 136 S. Ct. 1938 (2016). There, the Court articulated the principle that, where a federal "statute 'contains an express pre-emption clause,' we do not invoke any presumption against pre-emption but instead 'focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent.'" *Id.* at 1946 (quoting *Whiting*, 563 U.S. at 594).

The Court's treatments in *Gobeille* and *Puerto Rico*, however, have failed to eliminate the presumption's place in debates over statutory construction: The Vermont statute in *Gobeille* had invaded a "fundamental area of ERISA regulation," 136 S. Ct. at 946, and *Puerto Rico* concerned a federal statute whose "language is plain," 136 S. Ct. at 1946 (citation and internal quotation mark omitted)—suggesting that the Court might have reached the same result even if it had started with a contrary presumption. Litigants thus might yet argue, and lower courts might yet conclude, that *Gobeille* is unique to ERISA and that the principle finally announced in *Puerto Rico* is merely *dicta*. This case presents a good opportunity to erase any lingering uncertainty, for it involves a statute that may be susceptible of multiple "plausible constructions," *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 698 (2006), as well as a lower-court decision that expressly rests on the presumption against preemption (Pet. App. 7a, 47a-54a). The Court should take this opportunity to provide guidance and certainty to future courts and litigants, by decisively eliminating the presumption against preemption in express preemption cases.

B. The Court's approach in *Puerto Rico* is the correct one. Most significantly, it best comports with the text and history of the Supremacy Clause's provision that, "any Thing in the Constitution or Laws of any State to the Contrary notwithstanding," "the Laws of the United States ... shall be the supreme Law of the Land." U.S. Const. art. VI, cl. 2. As a plurality of this Court explained in *PLIVA*, the "any Thing" clause "is a *non obstante* provision," employed

"to specify the degree to which a new statute was meant to repeal older, potentially conflicting statutes in the same field." 564 U.S. at 621-22 (plurality op.) (citing Caleb Nelson, *Preemption*, 86 Va. L. Rev. 225, 234, 238-42, 252-53 (2000)).

In the case of the Supremacy Clause, the *non obstante* language extends to "*any* Thing" in state law, demonstrating that the Framers intended the Supremacy Clause to have the effect of *entirely* overcoming the traditional presumption against implied repeals (the historical antecedent to a presumption against preemption). The authors of the Constitution "did not want courts distorting the new law to accommodate the old." *Id.* at 622 (citing Nelson, *supra*, at 240-42). To the contrary, the Clause's historical purpose was "to remedy one of the chief defects in the Articles of Confederation by instructing courts to resolve state-federal conflicts in favor of federal law." David Sloss, *Constitutional Remedies for Statutory Violations*, 89 Iowa L. Rev. 355, 402 (2004). A principle that courts should favor an unnatural statutory construction just to avoid invalidating state laws runs contrary to this purpose. And it is thus unsurprising that there is no historical "support ... for the conclusion that the [F]ramers intended any ... presumption to be read into [the Supremacy Clause]." Marin R. Scordato, *Federal Preemption of State Tort Claims*, 35 U.C. Davis L. Rev. 1, 30 (2001). Instead, the Framers would have regarded the Clause as rejecting any "general presumption that federal law does not contradict state law." Nelson, *supra*, at 293; *see also, e.g.*, Jack Goldsmith, *Statutory Foreign Affairs Preemption*, 2000 Sup. Ct. Rev. 175, 184 (Clause was "designed precisely to

eliminate any residual presumption" against implied repeals of state law in the face of federal law).

The Supremacy Clause is thus best read to instruct courts facing preemption questions to employ ordinary tools of construction: In most cases they should "look no further than 'the ordinary meanin[g]' of federal law" and "should not distort federal law to accommodate conflicting state law." *PLIVA*, 564 U.S. at 623 (plurality op.) (quoting *Wyeth v. Levine*, 555 U.S. 555, 588 (2009) (Thomas, J., concurring in judgment)).

C. The plain-meaning approach of *Puerto Rico* and the *PLIVA* plurality, moreover, appropriately respects the separation of powers. As this Court has frequently stated, "the ultimate touchstone in every pre-emption case" is Congressional intent. *Wyeth*, 555 U.S. at 565 (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996)). And as with every statute, the language selected by Congress "necessarily contains the best evidence" of Congressional intent. *Whiting*, 563 U.S. at 594; *accord, e.g.*, *West Virginia Univ. Hospitals, Inc. v. Casey*, 499 U.S. 83, 98 (1991). By focusing on the words enacted by Congress, guided where necessary by normal statutory-construction tools, courts avoid imposing artificial barriers to the accomplishment of Congress's aims. In contrast, the judicially-created presumption against preemption artificially restrains Congress's power, "risk[ing] ... illegitimate expansion of the judicial function" through unintended narrowing of statutory language. *See* Viet D. Dinh, *Reassessing the Law of Preemption*, 88 Geo. L.J. 2085, 2092 (2000).

A presumption against preemption also risks upsetting the federal-state balance established by the Constitution. Where Congress foresees conflict with state law, it faces a Hobson's choice between two undesirable options if constrained by such a presumption. It might try to enumerate every kind of law that it wishes to preempt. But this creates an absurd situation in which a "statute that says *anything* about pre-emption must say *everything*; and it must do so with great exactitude, as any ambiguity concerning its scope will be read in favor of preserving state power." *Cipollone*, 505 U.S. at 548 (Scalia, J., concurring in judgment in part and dissenting in part). Such a patchwork of specific preemption clauses, moreover, would "disrupt the constitutional division of power between federal and state governments" by unduly enabling states to find and exploit loopholes in federal statutory schemes. *See* Dinh, *supra*, at 2092.

Alternatively, Congress could enact sweeping preemptive language creating exclusive federal authority over an entire field in which the States have no authority to regulate whatsoever. But that too may distort Congressional intent wherever its goal is merely to regulate in discrete areas, leaving other subjects to the States. A presumption against preemption makes it more difficult to draw such fine lines, limiting Congress's ability to achieve its aims while respecting traditional areas of state regulation.

The way to avoid this Hobson's choice is to disavow an extra-constitutional presumption against preemption, and instead to employ, in preemption cases as in others, the ordinary tools of statutory

construction—text, context, structure, history, purpose—to discern Congress's preemptive intent.

D. The typical rationale advanced for the presumption against preemption is putative respect for "principles of federalism and respect for state sovereignty." *Cipollone*, 505 U.S. at 533 (Blackmun, J., concurring in part and dissenting in part). But those justifications fail for reasons set forth above.

Concerns about protecting the federal system enacted by the Constitution are fully answered by the Supremacy Clause itself. A central part of the Framers' scheme was to permit Congress, acting within the scope of its powers, to override state law where necessary to the national interest. *See, e.g.*, Sloss, *supra*, at 401-02. It thus does not matter how "compelling" a State's interest is in regulating in an area preempted by Congress: "under the Supremacy Clause, from which our pre-emption doctrine is derived, *any* state law"—even one "clearly within a State's acknowledged power, which interferes with or is contrary to federal law"—"must yield." *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 108 (1992) (internal quotation marks omitted). Where Congress has the power to regulate, the forum for addressing federalism questions such as the "wisdom of national regulation" and the "balance between regulatory uniformity and policy innovations" is the Capitol, not the courthouse. *See* Dinh, *supra*, at 2092. Maintaining a presumption against Congress's exercise of its constitutional authority alters rather than protects the federal scheme.

The Supremacy Clause also answers objections rooted in state sovereignty, for it expressly proclaims

that the States' regulatory authority is subordinate to federal power. And, as discussed, a presumption against preemption upsets the federal-state balance, both restricting the ways in which Congress can seek to address nationwide problems and encouraging it to adopt overbroad schemes in order to prevent state intrusion.

Neither federalism nor state sovereignty is harmed by a rule under which Congress's words are given their ordinary meaning in the preemption context, as in any other. And where Congress has expressly determined that the best course is to override state regulatory authority, application of a presumption against preemption will undesirably encourage the development of a patchwork of state regulations to fill "holes" purportedly (but perhaps unintentionally) left by Congress in its statutory scheme. To avoid that outcome, this Court should explicitly reaffirm that the rule in *Puerto Rico* applies in all express-preemption cases.

II. FEHBA PREEMPTS STATE ANTI-SUBROGATION LAWS

In the absence of a presumption against preemption, the construction of § 8902(m)(1) adopted by the Missouri Supreme Court cannot stand. The best reading of the statute is that Congress expressly intended to preempt state anti-subrogation laws. It provides, in relevant part, that federal law preempts state-law regulation of FEHBA plan provisions "which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). The question for preemption purposes is whether contractual

subrogation and reimbursement provisions fall within the scope of that clause. They do.

First, FEHBA contract terms concerning subrogation and reimbursement "relate to" the "extent" and "provision" of employees' "coverage" and "benefits," *id.*, because such terms impose conditions and restrictions on the extent of coverage and benefits provided under the plan. Specifically, as the Tenth Circuit has explained, "a carrier's contractual right to reimbursement and subrogation *arises from* its payment of benefits; and an enrollee's ultimate entitlement to benefit payments *is conditioned upon* providing reimbursement from any later recovery or permitting the Plan to recover on the enrollee's behalf." *Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1106 (10th Cir. 2015) (emphases added). In other words, reimbursement and subrogation provisions "relate to" the provision and extent of benefits because they are "limitations on the payment of benefits." *Bell v. Blue Cross & Blue Shield of Oklahoma*, 823 F.3d 1198, 1203 (8th Cir. 2016). Reimbursement and subrogation are integral components of the coverage and benefit schemes of contracts of which they are a part, and thus necessarily "relate to" those schemes under the ordinary meaning of the words.

Second, even setting aside the question whether subrogation and reimbursement "relate to" "coverage" and "benefits" themselves, they clearly "relate to" "payments with respect to benefits." 5 U.S.C. § 8902(m)(1). A subrogation or reimbursement clause in fact directly provides for "payments with respect to benefits": Where the recipient of benefits brings a claim against a third party, the contract al-

lows the insurer to seek repayment of benefits already paid—creating a new payment obligation that is directly tied to the initial benefit payment. *See Bell*, 823 F.3d at 1204 (subrogation or repayment clause "relates to 'payments with respect to benefits' because, after an insured recovers from a third party, the contract results in repayment of funds that were previously received as benefits").

The Missouri Supreme Court's decision provides no basis to conclude that this ordinary-meaning reading of the statute is incorrect. Rather, the decision below rests on the presumption against preemption, reasoning that the presumption demanded a narrow reading of the statutory phrase "relate to," so as to "requir[e] a direct and immediate relationship to the insurance coverage and benefits at issue." Pet. App. 51a-52a. And respondent, in his brief in opposition (at 22-25), similarly failed to engage with the statutory text—relying exclusively on the presumption against preemption and the purported need to narrowly interpret § 8902(m)(1). The presumption against preemption is thus an integral step in any argument in favor of the decision below. A holding that no such presumption applies in an express-preemption case leaves the decision below without foundation and requires its reversal.

CONCLUSION

The Court should hold that no presumption against preemption applies where Congress has enacted an express preemption provision, and should reverse the decision below.

Respectfully submitted,

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COVENTRY HEALTH CARE OF MISSOURI, INC.,
fka Group Health Plan, Inc.,
Petitioner,

v.

JODIE NEVILS,
Respondent.

On Writ of Certiorari to the Supreme Court of Missouri

BRIEF OF *AMICI CURIAE* CONSTITUTIONAL AND ADMINISTRATIVE LAW SCHOLARS IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICI CURIAE*

Amici law professors (listed in Appendix A) are leading scholars and teachers of constitutional and administrative law who submit this brief in their individual capacities, not on behalf of their institutions. They study and write on federal preemption of state law, including the ways in which courts can and should discipline agencies to consider federalism values. *Amici* have an interest in promoting judicial review that requires agencies to take state regulatory interests seriously when their rules would preempt state law. *Amici* submit this brief to demonstrate that Petitioner's view of judicial deference to agency preemption would encourage agencies to ignore state interests when adopting broad interpretations of federal statutes to preempt state law.[1]

Amici have a range of views on how federalism affects the analysis required by *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984). But all agree that agency preemption is not subject to ordinary *Chevron* deference without close judicial review of the agency's interpretation or consideration of the presumption against preemption. Some *amici* would place questions of preemption outside *Chevron*'s domain unless Congress has expressly authorized an agency to interpret a preemption provision. Thus,

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[1] The parties have consented to the filing of this brief in letters on file in the Clerk's office. Pursuant to S. Ct. R. 37.6, *amici* state that no counsel for any party authored this brief in whole or in part, and no person or entity, other than *amici*, their members, or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. *Amici* law professors received no compensation for offering the views reflected herein.

agency positions on federalism would be treated only under the regime of *Skidmore v. Swift*, 323 U.S. 134 (1944). Other *amici* would require agencies to consider federalism, subject to searching judicial review of the quality of the agency's decisionmaking at *Chevron* Step Two or under arbitrary-and-capricious review. *Amici* share the concern that any framework for judicial review of agency preemption must ensure that the usual balance between state and federal authority is respected; this includes acknowledgment that Congress should be clear when it chooses to displace state law. But Petitioner's proposed framework would effectively eliminate that presumption against preemption whenever an agency interprets an express preemption provision. This broad view of agency authority is not mandated by this Court's precedents and risks disrupting the constitutional distribution of federal and state authority.

INTRODUCTION AND SUMMARY OF ARGUMENT

Whether an agency has the authority to preempt state law is a matter of considerable importance in an era where states and federal agencies share authority within virtually all fields of regulation. The Federal Employee Health Benefits Act ("FEHBA") includes a "puzzling" preemption provision that raises this question anew:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued

> thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1); *see Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 698 (2006) (explaining that Section 8902(m)(1) is a "puzzling" provision "open to more than one construction"). The State of Missouri, like the vast majority of states, has long regulated contractual subrogation or reimbursement clauses in personal injury cases. The Office of Personnel Management ("OPM"), however, promulgated a rule concluding that Section 8902(m)(1) gives preemptive effect to subrogation clauses in FEHB contracts. 5 C.F.R. § 890.106(h). In a single sentence, OPM incorrectly concluded its rule had no new federalism impacts. Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery, 80 Fed. Reg. 29,203 (May 21, 2015). Invoking *Chevron* deference, Petitioner argues that OPM's interpretation of the scope of FEHBA's preemption provision is authoritative.

This is not a case for *Chevron* deference. In reviewing OPM's interpretation, this Court should take into account that Congress "legislates against the backdrop of certain unexpressed presumptions," including "those grounded in the relationship between the Federal Government and the States." *Bond v. United States*, 134 S. Ct. 2077, 2088 (2014). This Court's precedents demonstrate that federalism has always disciplined a court's analysis of administrative action that displaces state law.

As this Court explained in *McVeigh*, 547 U.S. at 698, Section 8902(m)(1) is ambiguous, "puzzling," and warrants a "modest reading." Facing active litigation in

state and federal courts over the provision's meaning, OPM issued a rule that read Section 8902(m)(1) broadly to preempt state laws that would "prevent or limit subrogation or reimbursement rights under FEHB contracts." 80 Fed. Reg. at 29,203. And in so doing, the agency did not consider the wisdom of displacing state authority in tort law and insurance law, areas of traditional state concern. Instead, OPM offered a boilerplate assurance that its "rule restates existing rights, roles and responsibilities of State . . . governments." *Id.* at 29,204.

Deferring to OPM under *Chevron* would encourage agencies to preempt state law without regard to the usual balance between state and federal authority. Judicial review should at a minimum discipline agencies to consider federalism values. Agencies do not have special expertise to decide preemption questions. *Chevron* itself explained that deference is merited because agencies have political accountability and policy expertise to "reconcil[e] conflicting policies," and have "more than ordinary knowledge" of the "force of the statutory policy in the given situation." *Chevron*, 467 U.S. at 844 (citations omitted). When it comes to preemption, however, agencies must reconcile their own interests in national uniformity with structural and constitutional concerns presented by federalism. Courts' "ordinary knowledge" encompasses these federalism concerns. Judicial review of agencies' preemptive action can and should discipline agencies to consider federalism and protects states' regulatory interests where agencies fail to do so.

OPM's rulemaking *confirms* the need for searching judicial review of agency preemption. The agency

offered no analysis of the wisdom of displacing the usual balance between state and federal authority in the regulation of torts and insurance contracts. Far from being authoritative, the agency's rule does not embody the sort of reasoned judgment that might warrant judicial deference.

This Court, therefore, should reject the approach to judicial review offered by the Petitioner and its *amici*. Under their approach, courts would give only a cursory review to an agency's interpretation of a statute's preemption clause under *Chevron* Step Two. *See* Pet'r Br. 45-46; U.S. Br. 24. As a result, neither the agency nor a federal court would be required to give meaningful consideration to states' regulatory interests or the constitutional balance of state and federal authority. *See* Pet'r Br. 45; U.S. Br. 23-24. On their view of this Court's precedents, OPM's perfunctory discussion of federalism appears to be followed by perfunctory judicial review.

This Court, however, has always conducted a searching review to ensure that agency preemption is consistent with congressional intent. It has consistently applied the presumption against preemption in cases where an agency's interpretation of a statute tests the boundaries of its delegated authority. Indeed, this Court has counseled that an analysis of an ambiguous preemption provision should begin with the presumption and that interpretation of FEHBA's preemption provision in particular should be a "modest" one—a view that OPM does not even appear to have considered. *McVeigh*, 547 U.S. at 698. Petitioner and its *amici* invite this Court to break new ground by giving strong *Chevron* deference to OPM's

broad and unreasoned vision of FEHBA preemption. This Court should reject that invitation.

ARGUMENT

I. Judicial Review Is Necessary To Discipline Agencies To Consider Federalism Values.

Under this Court's federalism jurisprudence, statutory interpretation is one of the safeguards of the allocation of authority between state and federal governments. When interpreting statutes, "it is incumbent upon the federal courts to be certain of Congress' intent before finding that federal law overrides . . . the usual constitutional balance between the States and the Federal Government." *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991) (citations and quotation marks omitted). As this Court has explained, Congress "legislates against the backdrop of certain unexpressed presumptions," including "those grounded in the relationship between the Federal Government and the States." *Bond*, 134 S. Ct. at 2088 (citations and quotation marks omitted). Against this backdrop, structural and political safeguards play a vital role in maintaining the constitutional balance between states and the federal government. Federalism-based presumptions reinforce these safeguards and thus help preserve state authority.

This Court has yet to specify how it might review an agency's preemptive interpretation of federal law while maintaining respect for "the States [as] independent sovereigns in our federal system." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). Petitioner and its *amici* would eliminate consideration of the crucial "backdrop" of federalism-based presumptions that

Congress takes for granted when it legislates and that this Court routinely applies when interpreting the preemptive scope of a federal statute. *See Bond*, 134 S. Ct. at 2088. This Court's jurisprudence does not mandate the Petitioner's approach, which would upset the usual federal-state balance in an era where there is pervasive overlap between the authority of states and that of federal agencies.

A. Agencies Do Not Have Special Expertise In Assessing The Constitutional Balance Of Federal And State Powers.

Petitioner and the United States assume that an agency's policy expertise necessarily extends to evaluating the limits that federalism places upon federal agency action. Pet'r Br. 43; U.S. Br. 10. To the contrary, an agency's authority to implement federal regulatory programs is no guarantee of competence to determine the proper balance of federal and state law.

Whether an ambiguous statute should be interpreted to preempt state law implicates more than technical questions of federal regulation or the convenience of national uniformity that preemption provides. To be sure, agencies have a role to play in assessing how state law may affect federal regulation. *See Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 883 (2000). Although the allocation of authority between the state and federal governments is not a technical question, federal agencies implementing federal regulation day in and day out may have special insight into "how state law affects the regulatory scheme." *Wyeth v. Levine*, 555 U.S. 555, 576 (2009). And, in some cases, a federal agency's dependency upon states for the success of a specific regulatory program may

encourage the agency to consider state regulatory interests. *See* Gillian E. Metzger, *Administrative Law as the New Federalism*, 57 Duke L.J. 2023, 2075 (2008). But setting policy at the federal level does not train regulators to understand the "overall distribution of government authority and the intrinsic value of preserving core state regulatory authority." Nina A. Mendelson, Chevron *and Preemption*, 102 Mich. L. Rev. 737, 742 (2004); *see also* Ernest A. Young, *Executive Preemption*, 102 Nw. U. L. Rev. 869, 889 (2008).[2] Nor does determining federal policy provide any unique insight into the meaning of state law. Thomas W. Merrill, *Preemption and Institutional Choice*, 102 Nw. U. L. Rev. 727, 755 (2008). In contrast, courts routinely grapple with these structural concerns.

Judicial review of agency preemption is thus critical to ensure consideration of state interests and federalism values and to preserve the balance between state and federal authority in an era where there is significant federal agency presence in areas of traditional state authority. Federal agencies are not necessarily accountable to the states. *See* Young, *Executive Preemption*, *supra*, at 889. And national uniformity will always be convenient; agencies will always have good reason to prefer the low cost of implementing one standard instead of many. *See* Health Insurers Br. 15-27. Judicial review, then, is needed to ensure that agencies consider a state's

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[2] Agencies' programmatic focus means they may "excel on . . . pragmatic variables," while "fall[ing] short" on constitutional questions "concerning the division of authority between the federal government and the states." Thomas W. Merrill, *Preemption and Institutional Choice*, 102 Nw. U. L. Rev. 727, 755 (2008).

regulatory interests and is necessary to ensure that preemption is consistent with congressional intent and constitutional values.

Such was the case in *Wyeth*, where this Court rejected the Food and Drug Administration's ("FDA's") conclusion that its approval of drug labels preempted state tort law. 555 U.S. at 581. The FDA had failed to consider the value added by local regulation, including that state law may "offer an additional, and important, layer of consumer protection that complements [agency] regulation." *Id.* at 579; *see* David C. Vladeck, *Preemption and Regulatory Failure Risks*, *in* Preemption Choice: The Theory, Law, and Reality of Federalism's Core Question 54, 56 (William W. Buzbee ed., 2009) (explaining that state tort law provides a "safety net" that a federal agency cannot itself provide). In rejecting the agency's preemption statement, this Court "identif[ied] state law as a mechanism to guard against federal agency failure." Gillian Metzger, *Federalism and Federal Agency Reform*, 111 Colum. L. Rev. 1, 30 (2011).[3]

Given these general principles, how should the Court review the regulation at issue here? The answer is with caution.

One need look no further than the OPM's federalism impact statement in this case to understand why. The OPM's statement gives no reason to think that it has

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[3] This Court was similarly concerned with federal agency failure and overreach in other recent preemption decisions. Metzger, *Agency Reform*, *supra*, at 27-28 (discussing *Altria Group Inc. v. Good*, 555 U.S. 70 (2008), and *Cuomo v. Clearing House Ass'n, L.L.C.*, 557 U.S. 519 (2009)).

special expertise in determining preemption questions. Its consideration of federalism was a boilerplate assertion that its rule did not have new federalism impacts, but instead "restate[d]" the existing allocation of state and federal authority. 80 Fed. Reg. at 29,204. OPM's 2012 opinion letter to health insurance carriers was similarly conclusory, containing no analysis of state interests in preemption. Instead, OPM merely stated the following: "OPM has consistently recognized that the FEHBA preempts state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts, and we continue to maintain this position." FEHB Program Carrier Letter No. 2012-18, at 2 (June 18, 2012), available at https://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-18.pdf. Thus, the OPM has consistently failed to address states' regulatory interests when explaining its position on FEHBA preemption.

This perfunctory treatment of federalism may be unsurprising. The OPM's charge is to recruit and to manage the federal workforce. *See, e.g.*, 5 U.S.C. § 8901 et seq. As a workforce manager, OPM has an obvious interest in the convenience, not to mention the policymaking authority, that comes with preemption of state law.[4] But it does not have a "mandate to represent state interests." Young, *Executive*

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[4] This Court expressed a similar concern in *King v. Burwell*, 135 S. Ct. 2480 (2015): "It is especially unlikely that Congress would have delegated this decision to the IRS, which has no expertise in crafting health insurance policy of this sort. . . . This is not a case for the IRS." *Id.* at 2489 (citing *Gonzales v. Oregon*, 546 U.S. 243, 266–267 (2006)) (Roberts, C.J.).

Preemption, *supra*, at 878. And its federalism impact statement smacks of the very kind of "tunnel vision" that judicial review is designed to correct. *Cf.* Merrill, *supra*, at 755 (explaining that a "critical problem" with agency preemption "is one of tunnel vision"); Mendelson, *Preemption*, *supra*, at 784 (explaining that agency "federalism impact analyses," though required by executive order, "are scarce at best"); Catherine M. Sharkey, *Preemption by Preamble: Federal Agencies and the Federalization of Tort Law*, 56 DePaul L. Rev. 227, 228 (2007) (discussing "agency momentum towards increased preemption"). Thus, OPM's rulemaking underscores the need for close judicial review to ensure the proper state-federal balance of authority.

This Court should not adopt an approach to judicial review that requires deference whenever an agency promulgates a rule that recites an interest in national uniformity. If administrative federalism is to remain a reality, judicial review must discipline agencies to take federalism values seriously.

B. Courts Should Incorporate Federalism Values Into The Framework For Review Of Agency Preemption.

Petitioner and its *amici* would sweep away these concerns with a simple invocation of the OPM's authority to promulgate regulations and the purportedly overriding concern for national uniformity. In their view, the presumption against preemption, a bedrock rule of statutory interpretation, is not relevant where Congress has enacted a preemption provision and given an agency general authority to adopt regulations. *See* Pet'r Br. at 36; Chamber's Br. at 5;

U.S. Br. at 11. Instead, they argue, *Chevron* requires this Court to defer to the OPM's boilerplate assessment of federalism.

To the contrary, this Court has explained that "*Chevron* deference . . . is not afforded merely because the statute is ambiguous and an administrative official is involved." *Gonzales v. Oregon*, 546 U.S. 243, 258 (2006). This Court has always required that an agency have delegated authority to resolve an ambiguity—a lesson only "heightened where the administrative interpretation alters the federal-state framework by permitting federal encroachment upon a traditional state power." *Solid Waste Agency of N. Cook County v. United States Army Corp of Eng'rs*, 531 U.S. 159, 173 (2001). Indeed, federalism concerns have consistently driven this Court's view of agency preemption.

1. According to Petitioner and its *amici*, an agency has authority to issue a binding rule preempting state law as long as the enabling statute refers to preemption and the agency has general authority to promulgate rules. Pet'r Br. 43; U.S. Br. 22. Their proposed rule is far too sweeping and misconstrues this Court's precedent.

This Court's preemption jurisprudence has analyzed agency preemption against the backdrop of federalism. *Cf. Bond*, 134 S. Ct. at 2088 (explaining that Congress "legislates against the backdrop of certain unexpressed [federalism-based] presumptions"). Several of its cases, such as *Wyeth*, analyze the statutory scheme in fine detail, with the Court assuring itself of the scope of the statute's preemptive power while giving an agency's views the weight their reasoning deserves, if any. *See Wyeth*, 555 U.S. at 576-77 (explaining that Court has

"attended to an agency's explanation of how state law affects the regulatory scheme" but has "not deferred to an agency's conclusion that state law is preempted").[5] What the Court has not done is adopt a framework that would make federalism concerns irrelevant to judicial review of agency preemption.

When confronted with an express preemption clause in *Watters v. Wachovia*, 550 U.S. 1 (2007), the Court did not defer to the agency under *Chevron*. The district court had given *Chevron* deference to the Comptroller General's preemptive interpretation. *Id.* at 10. But this Court independently concluded that state law stood as an obstacle to federal banking law and therefore was preempted. *Id.* at 20. When invoking implied preemption, this Court treated the close

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[5] Some scholars have proposed this type of clear-statement rule to limit *Chevron*'s domain in preemption cases. *See* Nina A. Mendelson, *A Presumption Against Agency Preemption*, 102 Nw. U. L. Rev. 695, 699 (2008) (arguing for clear-statement requirement to confer broad preemptive power on agencies); Merrill, *supra*, at 767 (same). Other scholars have argued that federalism concerns are better addressed with close judicial review under the *Chevron* framework or under arbitrary-and-capricious review. *See* Metzger, *New Federalism*, *supra*, at 2104-2105 (arguing that great weight should be placed on quality of agency's reasoning); Brian Galle & Mark Seidenfeld, *Administrative Law's Federalism: Preemption, Delegation, and Agencies at the Edge of Federal Power*, 57 Duke L.J. 1933, 2011-12 (2008). The common thread is that the Court's preemption jurisprudence supports searching review of agency preemption. *See Wyeth*, 555 U.S. at 576-581; Metzger, *Agency Reform*, *supra*, at 17-18. This Court need not specify where federalism concerns enter the *Chevron* framework to resolve this case. *See infra* Pt. II.

question as one for careful judicial review to determine whether Congress intended to preempt state law.[6]

Similarly, this Court in *Gonzales v. Oregon* declined to defer to an agency's attempt to preempt state law based upon the federalism impacts. It denied both *Auer v. Robbins*, 519 U.S. 452 (1997) and *Chevron* deference to the Attorney General's interpretive rule that would have revoked the licenses of local doctors who prescribed drugs to assist patients with suicide. *Gonzales*, 546 U.S. at 268. *Gonzales* turned in part on the Court's conclusion that it need not accord heightened deference to the Attorney General's view because he had not followed the procedures mandated by the Controlled Substances Act. *Id.* at 256. But the central issue in the case, the Court explained, was one of "[w]ho decides whether a particular activity is 'in the course of professional practice' or done for a 'legitimate medical purpose.'" *Id.* at 257 (citing the statute, 21 U.S.C. §§ 802(21) and 829(c)). Allowing the Attorney General to define those terms would hand "a single executive officer the power to effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality." *Id.* at 275. *Gonzales*, then, counseled that

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[6] OPM relied upon express preemption and Section 8902(m)(1) in its rulemaking. Nevertheless, the United States as *amicus* now offers that OPM's preemption decision was also based upon Section 8902(d)'s references to "benefits offered" and "limitations," which OPM did not mention at all in its rulemaking. U.S. Br. at 22. Petitioner does not, however, press a claim of implied preemption, which would be distinct from the theory of express preemption that OPM actually advanced. *Cf. Watters*, 550 U.S. at 21 (holding that statute impliedly preempted state law and not reaching the question of an express preemption clause's scope).

courts should carefully assess the scope of agency's delegated authority whenever a rule threatens to sweep away an area of traditional state regulation.

In short, this Court has not applied ordinary *Chevron* review to hold that an agency's preemptive interpretation of an ambiguous federal statute is authoritative. Petitioner and its *amici* focus upon this Court's decision in *City of Arlington, Tex. v. F.C.C.*, but, by this Court's reasoning, that case "ha[d] nothing to do with federalism." 133 S. Ct. 1863, 1873 (2013). The Petitioner also makes much of this Court's decision in *Cuomo v. Clearing House Association, LLC*, 557 U.S. 519 (2009). Pet'r Br. 52. But the Court in *Cuomo* concluded, after a detailed statutory analysis, that the statute clearly foreclosed the agency's construction. *See* 557 U.S. at 536. If anything, *Cuomo* "suggests that more authorization of administrative preemption than simply an express preemption clause is needed for the agency's views on preemption to get strong deference." Metzger, *Agency Reform*, *supra*, at 14 n.53.

2. The presumption against preemption demands more searching judicial review than the Petitioner's proposed framework would direct. This Court has long recognized that "Congress does not cavalierly pre-empt state law." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). Out of respect for "the States [as] independent sovereigns in our federal system," *id.*, courts should "start with the assumption that the historic police powers of the States were not . . . superseded by [a statute] unless that was the clear and manifest purpose of Congress." *Id.* (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). This presumption — that Congress knows to speak plainly

when it chooses to displace state power— must ground "all pre-emption cases." *Id.*

The presumption against preemption vindicates values at the heart of this Court's federalism jurisprudence.[7] It ensures that decisions to preempt state law rest ultimately with Congress, whose intent is the "ultimate touchstone" of preemption analysis. *Wyeth*, 555 U.S. at 565 (internal quotation marks omitted). As this Court explained in *Gregory v. Ashcroft*:

> [I]nasmuch as this Court in *Garcia* [*v. San Antonio Metro. Trans. Auth.*, 469 U.S. 528, 550-54 (1985)] has left primarily to the political process the protection of the States against intrusive exercises of Congress' Commerce Clause powers, we must be absolutely certain that Congress intended such an exercise.

501 U.S. 452, 464 (1992). The presumption against preemption thus disciplines Congress to consider federalism values before preempting state law. See William N. Eskridge, *Vetogates,* Chevron, *Preemption*, 83 Notre Dame L. Rev. 1441, 1471 (2008) (noting that the presumption allows courts to ensure that Congress has adequately deliberated before preempting state law). The same should be true of agencies implementing Congress's regulatory statutes.

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[7] *See generally* Ernest A. Young, *"The Ordinary Diet of the Law": The Pre-sumption Against Preemption in the Roberts Court*, 2011 Sup. Ct. Rev. 253, 257-60 (2011) (tracing the development of the presumption against preemption as it fits into the Court's broader federalism jurisprudence).

This Court has invoked the presumption far more often than the "occasional articulation" suggested by Petitioner's *amici*. Chamber's Br. at 5. This includes cases examining the scope of an express preemption clause. In *Cipollone v. Ligget Group, Inc.*, 505 U.S. 504, 516 (1992), this Court relied upon the presumption when interpreting an express preemption provision, with Justice Blackmun explaining in his concurring opinion that "[w]e do not, absent unambiguous evidence, infer a *scope* of preemption beyond that which clearly is mandated by Congress' language." *Id.* at 533 (emphasis added). The Court invoked the presumption when it concluded that a statute's express displacement of state safety standards for medical devices did not extend to a state claim of defective design. *See Medtronic*, 518 U.S. at 485. It relied on its "basic" "duty to accept the reading that disfavors preemption" in construing a provision that plainly prohibited states from adopting certain types of labeling requirements for pesticides. *Bates v. Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005). And in *Altria Group v. Good*, this Court explained that "when addressing questions of *express* or implied pre-emption," courts should "begin their analysis" by "assum[ing]" that a Congressional intent to preempt must be "clear and manifest." 555 U.S. 70, 77 (2008) (emphasis added).

Petitioner and its *amici* urge this Court to eliminate the presumption against preemption in express preemption cases. Pet'r Br. at 36; Chamber's Br. at 8; U.S. Br. at 11. First, they argue that the Court has already held in *Puerto Rico v. Franklin California Tax-Free* Trust, 136 S. Ct. 1938 (2016), that the presumption is not relevant when interpreting an

express preemption provision. There, the Court explained that it would "not invoke any presumption against pre-emption," but did so after explaining that "the plain text of the Bankruptcy Code [could] begin[] and end[] [its] analysis." *Id.* at 1946. Thus, other tools of statutory construction may sometimes lead to a definitive answer on the question of a preemption provision's scope. But it does not follow that the presumption is "irrelevant." See Pet'r Br. at 36. Even where "federal law contains an express pre-emption clause, . . . the question of the substance and scope of Congress' displacement of state law still remains." *Altria*, 555 U.S. at 76.[8]

The statutory interpretation issue in this case is a good example why the presumption against preemption is relevant to questions of the scope of an ambiguous express preemption provision. FEHBA's preemption provision makes clear that Congress intended a federal contract to preempt state laws that differ on the types of covered medical care. That is the plain import of Section 8902(m)(1)'s preemption of state laws that "relate to the nature, provision, or extent of coverage or

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[8] *Franklin Trust* relied upon *Chamber of Commerce v. Whiting*, 563 U.S. 582, 594 (2011), which said simply that courts "focus on the plain wording of the [preemption] clause," without considering the role of presumptions if that wording is not plain, and upon *Gobeille v. Liberty Mutual Ins. Co.*, 136 S. Ct. 936, 946 (2016), which simply found the presumption against preemption displaced by longstanding interpretations of the ERISA statute. None of these cases purported to overrule *Altria* or *Bates*. It is incorrect, then, to say that the presumption is never triggered when this Court confronts an ambiguous express preemption clause. *See* U.S. Br. at 11. At the very least, this Court has not definitively foreclosed its application in express preemption cases.

benefits." 5 U.S.C. § 8902(m)(1); *see* H.R. Rep. 95-282, 5 (1977) (explaining that provision would preempt state laws "which specify types of medical care"). But Congress did not make clear whether it intended FEHB contracts to preempt state regulation of subrogation. *Cf.* Ernest A. Young, *"The Ordinary Diet of the Law": The Presumption Against Preemption in the Roberts Court*, 2011 Sup. Ct. Rev. 253, 272 (2011) ("The clarity of Congress's intentions with respect to negligent design hardly establishes that Congress also meant to preempt claims for negligent manufacture . . . ."). The presumption against preemption remains relevant to resolving that second, logically distinct question.

The presumption can warrant a modest reading of a statute's preemptive scope. It is one of the "context-specific[] factors" that courts use to assess ambiguous delegations, including how a broad interpretation of an otherwise opaque provision might intrude on state authority. *See Arlington*, 133 S. Ct. at 1876 (Breyer, J., concurring); Miriam Seifter, *Federalism at Step Zero*, 83 Fordham L. Rev. 633, 650 (2014) ("canons are applied *contextually*"). It is just this sort of "modest reading" that this Court applied to Section 8902(m)(1) in *McVeigh* but OPM failed to consider it in its rulemaking. *See McVeigh*, 547 U.S. at 698; *infra* Part II.A.

Second, *amicus* Chamber of Commerce contends that the presumption "cannot be justified on federalism grounds" and is inconsistent with the original understanding of the Supremacy Clause. Chamber's Br. at 4. It would follow that the presumption has no role to play in this Court's treatment of OPM's preemptive interpretation of the FEHBA. But the

presumption against preemption is firmly rooted and helps preserve the federal-state balance in the modern administrative state. *See Bond*, 134 S. Ct. at 2088 (Congress legislates against backdrop of federalism-based presumptions); *cf.* Young, *Presumption*, *supra*, at 324 ("courts can give effect to the Framers' original understanding of the Supremacy Clause . . . without rejecting [the presumption against preemption]"). In our "era of administrative federalism," federal regulatory policy plays an encompassing, perhaps even "outsized" role. Seifter, *supra*, at 635. The simple fact is that federal and state regulators occupy many, if not all, of the same regulatory spaces. The presumption against preemption plays an important role in ensuring that federal administration does not swallow administrative federalism.

II. The OPM's Preemptive Interpretation Is Not Due Deference.

In its preemption cases, this Court has exercised independent judgment on the question of preemption, even if it "attend[s] to" the agency's views and whatever weight they deserve. *Wyeth*, 555 U.S. at 576-77. It has not, however, treated an agency's preemptive interpretation as authoritative under ordinary *Chevron* review. The Court should not break new ground by in this case deferring to the OPM's interpretation. Deferring to the OPM would encourage federal agencies to disregard state interests when interpreting ambiguous statutes.

Federal agencies, no less than federal courts, should not lightly construe federal statutes to preempt state law. Whatever OPM's expertise in managing the federal civil service, it did not display any expertise in

considering federalism values. As this Court had already explained, a "modest reading" of the FEHBA's "puzzling" preemption provision "is in order." *McVeigh*, 547 U.S. at 697-98. The OPM instead adopted a broad interpretation of the preemption provision in anticipation of litigation. And in doing so, the OPM failed entirely to consider federalism values. This Court should not defer to the OPM's attempt to preempt state tort law and regulation of insurance.

A. State Regulation Of Reimbursement and Subrogation Reflects Important State Regulatory Interests.

The OPM's explanation of its broad interpretation of the FEHBA's preemption provision gives no account of the reasons behind Missouri's anti-subrogation law.[9] The agency's explanation amounted to this: "The interpretation of Section 8902(m)(1) promulgated herein comports with longstanding Federal policy and furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." 80 Fed. Reg. at 29,203. Recognizing that "[s]ome state courts have interpreted ambiguity in Section 8902(m)(1) to reach a contrary result," the agency applied its new rule not only to future cases, but also to pending ones. *Id.*

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[9] OPM's failure to consider state regulatory interests in its rulemaking precludes this Court from relying upon any *post hoc* assessment of them in reviewing OPM's preemptive interpretation. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016) ("It is not the role of the courts to speculate on reasons that might have supported an agency's decision." (citing *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947)).

Petitioner and its *amici* similarly are silent on a state's interests in regulating reimbursement and subrogation. But an understanding of state subrogation policies is crucial to assessing the preemption question in this case. The agency's lack of appreciation for the value of state policy making in this area underscores why a "modest reading" of FEHBA's preemption provision is appropriate and why this Court should not treat OPM's interpretation as authoritative. *McVeigh*, 547 U.S. at 698.

Missouri's anti-subrogation law is part of an ongoing dialogue among states regarding the regulation of tortious wrongs and health insurance. Missouri's rule is not an outlier. Not only Missouri, but over half of states limit an insurer's right to subrogation or reimbursement. *See* E. Farish Percy, *Applying the Common Fund Doctrine to an ERISA-Governed Employee Benefit Plan's Claim for Subrogation or Reimbursement*, 61 Fla. L. Rev. 55, 57, 65-66 (2009). As one of Petitioner's *amici* points out, Missouri is not the only state that prohibits subrogation. *See* Health Insurers Br. at 15-16 (citing Ariz. Rev. Stat. § 12-565; Conn. Gen. Stat. Ann. § 52-225a; N.J. Stat. Ann. § 2A: 15-97; N.Y. Gen. Oblig. Law § 5-335(a); 11 N.C. Admin. Code § 12.0319; Va. Stat. § 38.2-3405; *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 419 (Mo. Ct. App. 1965); Kan. Admin. Regs. § 40-1-20). States that have limited or prohibited reimbursement and/or subrogation have done so as an exercise of their traditional authority to provide for the health, safety, and welfare of their residents.

Subrogation or reimbursement clauses in health insurance contracts allow the insurer to recover its

costs when an insured individual has recovered, or has a right to recover, from a third party. Traditionally, subrogation was not favored under the common law, which prohibited "assigning" or "splitting a cause of action." Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. Rev. 237, 239 (1996). Missouri's court of appeals followed this consistent public policy when it held in 1965 that reimbursement or subrogation clauses in insurance contracts were invalid in a personal injury case. *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 424 (Mo. Ct. App. 1965). To permit subrogation would, the court explained, "lift[] the lid on a Pandora's Box crammed with both practical and legal problems." *Chumbley*, 394 S.W.2d at 425.

States have enunciated several public policy rationales for limiting or prohibiting subrogation and reimbursement. First, as the Missouri court of appeals noted, subrogation and reimbursement may "not, *in fact*, work a perceptible reduction in the premium charged for such coverage." *Chumbley*, 394 S.W.2d at 425; *see* Baron, *supra*, at 244 ("A number of courts have also come to recognize that the allowance of subrogation results in a pure windfall to the insurer with no corresponding adjustment in the premium charged."). Second, while subrogation is justified as necessary to prevent "double recovery," it may in fact lead to undercompensation; for instance, "items such as mental anguish and physical pain are not insurable and are rarely fully recoverable from tortfeasors." Baron, *supra*, at 245. Third, subrogation discourages settlement and can lead to protracted litigation. *See Chumbley*, 394 S.W. 2d at 425; Baron, *supra*, at 246. By prohibiting subrogation, Missouri — as well as the

seven other states that have also prohibited it — have simplified the process of litigation and recovery to protect consumers.

Other states have experimented with alternative solutions to problems that subrogation poses. At least nineteen states have limited subrogation through the "make whole" doctrine. AFHO State Survey of Reimbursement Laws in the Health Insurance Context (Feb. 2014) (cited in Health Insurers Br. at 15).[10] This doctrine holds that "an insurer is not entitled to subrogation unless and until the insured has been made whole for his or her loss." *Complete Health, Inc. v. White*, 638 So. 2d 784, 786 (Ala. 1994). Thus, the majority of states either prohibited or limited subrogation as "the harshness of subrogation . . . came to light." Baron, *supra*, at 261.

State regulation of subrogation is within the states' traditional authority over tort law and insurance law. Decentralized tort law is a "uniquely American" tradition that "has held up remarkably well." Gary T. Schwartz, *Considering the Proper Federal Role in American Tort Law*, 38 Ariz. L. Rev. 917, 921 (1996). The assignment or splitting of causes of action for personal injuries was traditionally prohibited at the common law. And the "regulation of insurance, though within the ambit of federal power, has traditionally been under the control of the States." *SEC v. Variable Annuity Life Ins. Co. of Am.*, 359 U.S. 65, 68-69 (1959).

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[10] Available at http://ermerlaw.com/PDFs/Feb2014%20FHOState SurveyWithMap.pdf.

This is not to say that Missouri or any other state is right about the burdens imposed by subrogation, or that OPM is wrong that allowing for it reduces cost in the overall insurance system. The question remains "[w]ho decides." *Gonzales* 546 U.S. at 257. Missouri's anti-subrogation law is part of an ongoing state dialogue about the problems of subrogation, one in which the majority of states have concluded subrogation must be limited or prohibited outright.

In a federal system, the application of the presumption against preemption of state law plays a crucial role in protecting space for those dialogues and in ensuring that these "laboratories of democracy" are not lightly shut down. *New State Ice v. Liebman*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting); *see Oregon v. Ice*, 555 U.S. 160, 171 (2009) (Court has "long recognized the role of the States as laboratories for devising solutions to difficult legal problems."). Federal agencies such as OPM have no special expertise in considering the constitutional value of state autonomy and interstate dialogue. *See supra* Pt. I.A. As a result, close judicial review is necessary to ensure that agency preemption does not disrupt the usual balance of federal and state authority when Congress has not authorized it to do so.

As this Court has already explained, Congress has not clearly indicated that it intended to authorize OPM-approved contracts to preempt state laws concerning subrogation. In *McVeigh*, this Court reasoned that Section 8902(m)(1) is a "puzzling measure" that "declares no federal law preemptive," but instead gives preemptive effect to terms in an OPM "negotiated contract." 547 U.S. at 697-98. It was "not

prepared to say" that an "OPM-BCBSA contract term would displace every condition that state law places" on reimbursement. *Id.* Instead, the Court concluded that a "modest reading" of Section 8902(m)(1) was appropriate. *See id.* at 698; *cf. CTS Corp. v. Waldburger*, 134 S. Ct. 2175 (2014) (Kennedy, J., concurring) (explaining that presumption against preemption "support[s]" a "narrow interpretation" of an express preemption provision); *Empire HealthChoice Assur., Inc. v. McVeigh*, 396 F.3d 136, 145 (2d Cir. 2005) (Sotomayor, J.) (invoking presumption against preemption when interpreting Section 8902(m)(1)).

B. In Adopting A Broad Interpretation Of The Preemption Provision, The OPM Failed Entirely To Consider Federalism Values.

The OPM did not adopt a modest reading of Section 8902(m)(1). Instead, it read the provision to give preemptive effect to subrogation clauses in OPM-approved contracts. According to the agency, these clauses "relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits," not because they prescribe anything with respect to coverage or benefits, but instead because they "lower[] the cost of benefits, and create[] greater uniformity in benefits and benefits administration." Proposed Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery, 80 Fed. Reg. 931, 932 (January 7, 2015); *see also* Final Rule, 80 Fed. Reg. at 29,203 (explaining only that "subrogation recoveries translate to premium cost savings," and saying nothing about its relationship to coverage or benefits). In announcing this broad interpretation, the OPM failed entirely to discuss any

countervailing concerns, much less the federalism values that this Court has made clear are necessary considerations in cases of agency preemption.

In striving to defend OPM's failure to discuss state regulatory interests or countervailing federalism concerns, the Petitioner and its *amici* ask this Court to conduct cursory judicial review at *Chevron* Step Two. On their view, OPM's preemptive interpretation is "authoritative" because OPM promulgated a conclusory rule in 2015 repeating its conclusory view of preemption from a 2012 carrier letter. Pet'r Br. 46. Thus, the Petitioner's approach would not require a reviewing court, much less agencies, to take federalism seriously when determining if preemption is consistent with congressional intent.

Yet OPM's failure to take federalism seriously is the type of agency failure that demands searching judicial review. This Court has already made clear that close judicial review of agency preemption is necessary to maintain the constitutional balance of federal and state authority. Therefore, this Court has reasoned that a court must apply independent judgment on the ultimate question of preemption, even if it gives an agency's views the weight their reasoning deserves. *See Wyeth*, 555 U.S. at 576 (explaining that Court has "not deferred to an agency's conclusion that state law is pre-empted," but instead has "attended to an agency's explanation of how state law affects the regulatory scheme"). The Court should not accept the Petitioner's invitation to break new ground by deferring under *Chevron*. Instead, it should adhere to an approach that preserves the presumption against preemption and directs the reviewing court to consider

the usual balance of federal and state authority and to take a close look at the quality of the agency's decisionmaking.

Such an approach is consistent with *Skidmore*, 323 U.S. at 140, which directs courts to give weight to an agency's views to the extent they have the "power to persuade."[11] *Skidmore* requires a reviewing court to consider the "thoroughness" and "validity" of an agency's statutory interpretation, as well as its "consistency" with other agency pronouncements. *Id.*

This Court has also required consideration of the quality of agency decisionmaking at *Chevron*'s second step and under hard look review. An agency's interpretation is not authoritative under *Chevron* where it is unreasonable. *See Entergy Corp. v. Riverkeeper, Inc.*, 556 U.S. 208, 218 (2009). And an agency that has not provided a "reasonable explanation for its action" is an agency whose decisionmaking fails hard look review. *See F.C.C. v. Fox Television Stations Inc.*, 556 U.S. 502, 515 (2009). This Court should not treat agency preemption as authoritative under *Chevron* without close judicial review of the agency's interpretation or consideration of the presumption against preemption. Instead, as this Court has made clear, its review of an administrative interpretation that "alters the federal-state framework" may be "heightened," *Solid Waste Agency of N. Cook County*,

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[11] *See* Mendelson, Chevron *and Preemption*, *supra*, at 742 ("A court should retain not only the ability to apply the *Rice* presumption against preemption, but also the discretion to take account of an agency interpretation on preemption under a regime such as *Skidmore v. Swift*.").

531 U.S. at 172-73, and that close review should extend to the quality of an agency's decision to preempt state law.[12]

None of the factors that might counsel in favor of judicial deference in preemption cases are present here. The OPM did not consider the presumption against preemption; it did not offer a "nonperfunctory" federalism impact statement; it did not offer any "special expertise in identifying" a policy conflict between state and federal law; it did not have the benefit of comments from state officials; and it did not offer a "limiting principle" on its broadly preemptive interpretation. Young, *Executive Preemption*, *supra*, at 891-92 (discussing these factors as bearing upon judicial deference to an agency's preemptive interpretation). Instead, the OPM's explanation of its rule is little more than *ipse dixit* favoring preemption.

The OPM claimed to consider the federalism impacts of its rule. But it mustered nothing more than a perfunctory statement that its rule "restates existing rights, roles and responsibilities of State, local, or tribal governments." 80 Fed. Reg. at 29,203. This Court's

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[12] *See* William W. Buzbee, *Preemption Hard Look Review, Regulatory Interaction, and the Quest for Stewardship and Intergenerational Equity*, 77 Geo. Wash. L. Rev. 1521, 1568 (2009) ("[R]ecent major Supreme Court preemption precedents adopt a level of policy and factual scrutiny consistent with hard look review . . . ."); Galle & Seidenfeld, *supra*, at 2001 (proposing "amalgam of *Skidmore* and hard look review" for agency preemption); Metzger, *Administrative Federalism*, *supra*, at 2105-06 (developing "contextual approach" that would rely on arbitrary and capricious review, "with greater justification perhaps required only in some circumstances").

analysis of Section 8902(m)(1) in *McVeigh* belies the agency's boilerplate. As this Court made clear, Section 8902(m)(1) does not clearly state that state laws concerning subrogation and reimbursement are preempted. 547 U.S. at 697. And the OPM itself recognized that, under existing law, various state courts had concluded that Section 8902(m)(1) did not preempt state regulation of subrogation. In light of this Court's analysis, as well as state courts' analyses, the OPM's conclusion that its rule restated existing law does not warrant deferential treatment.

OPM's hasty interpretation may be explained by its apparent aim to address ongoing litigation about Section 8902(m)(1)'s scope. In its final rule, OPM purported to protect the "subrogation and reimbursement rights" of insurers against "state courts [that] have interpreted ambiguity in Section 8902(m)(1) to . . . allow state laws to prevent or limit subrogation or reimbursement." 80 Fed. Reg. at 29,203. It therefore provided that its rule would apply to pending as well as future cases. *Id.*

Given the litigation that it cited in its rulemaking, OPM was aware that its proposed rule would preempt the ongoing state dialogue about regulation of subrogation. Nevertheless, OPM provided only a 30 day period for comments, *see* 80 Fed. Reg. 29,203, which is half of the 60 day period that Executive Order 13,563 recommended to ensure that regulations are "based . . . on the open exchange of information and perspectives among State, local, and tribal officials" as well as other stakeholders. *See* Exec. Order 13,563, 76 Fed. Reg. 3821, 3821-22 (January 18, 2011). OPM discussed the three comments it received, each from

parties in favor of preemption. But OPM apparently did not have the benefit of views from the states, the National Association of Insurance Commissioners, the National Conference of State Legislatures, or any other organization representing state regulatory interests. OPM's procedures for considering the federalism impacts of preemption is not a model to be encouraged. To the contrary, the Administrative Conference of the United States has recommended that agencies adopt procedures to ensure "timely" consultation with states concerning preemption. *See* Administrative Conference Recommendation 2010-1, 76 Fed. Reg. 81, 83 (Jan. 3, 2011) (recommending "Updated Policies to Ensure Timely Consultation With State and Local Interests Concerning Preemption"); *see* Catherine M. Sharkey, *Inside Agency Preemption*, 110 Mich. L. Rev. 521 (2012) (reviewing mechanisms for federal agencies to consult with state officials during rulemaking process). The predictable result of OPM's failure was a boilerplate federalism impact statement that, contrary to Executive Order 13,132, is conclusory and does not engage state regulatory interests at all. Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (August 10, 1999).

Finally, OPM's interpretation is particularly troublesome because it imbues private contractual provisions with preemptive force. As this Court noted in *McVeigh*, FEHBA's preemption provision "is unusual in that it renders preemptive contract terms in health insurance plans." *McVeigh*, 547 U.S. at 697 (citing *Empire Healthchoice Assurance Inc. v. McVeigh*, 396 F.3d at 143-44 (Sotomayor, J.)). This "unusual" provision "warrant[ed] cautious interpretation," *id.*, which OPM failed entirely to do. Instead, after receiving only three comments, each from industry

representatives, OPM gave preemptive effect to insurers' contractual preferences.

In short, OPM failed entirely to consider state regulatory interests when adopting a broadly preemptive interpretation of Section 8902(m)(1). OPM's view of the preemptive scope of the FEHBA is not due deference.

CONCLUSION

The Missouri Supreme Court's decision should be affirmed.

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APPENDIX

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AND
BRIEFS

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COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ of Certiorari to the Supreme Court of Missouri

BRIEF OF THE MISSOURI ASSOCIATION OF TRIAL ATTORNEYS AS AMICUS CURIAE SUPPORTING RESPONDENT

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INTEREST OF AMICUS CURIAE[1]

The Missouri Association of Trial Attorneys (MATA), is a non-profit professional organization of approximately 1,400 trial attorneys in Missouri. MATA strives to promote the fair administration of justice, to preserve the integrity of the American adversary system, and to employ its members' knowledge and experience to advance the rights of all Missourians, and indeed, all Americans. Because its members frequently represent parties in personal-injury and product-liability suits that involve the recovery of medical expenses, MATA's members are aware of the vital role that Missouri's legal safeguards against insurer subrogation play in protecting the rights of injured parties and health care providers. MATA thus wishes to ensure that these protections—and similar state regulations around the country—remain robust. Accordingly, MATA has a strong interest in ensuring that the express preemption provision in the Federal Employee Health Benefits Act (FEHBA), 5 U.S.C. § 8902(m)(1), is interpreted to leave state restrictions on subrogation intact. This is the result that Congress intended, as a review of the Act's illuminating legislative history reveals. And it is the result that best respects the division of regulatory labor Congress envisioned when it enacted section 8902(m)(1).

SUMMARY OF THE ARGUMENT

States have traditionally operated with virtually unfet-

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[1] All parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no entity other than amicus or its counsel has made a monetary contribution to the preparation or submission of this brief.

tered authority to regulate the business of private insurance and the companies that provide it. Because of Congress's abiding respect for the states as separate sovereigns, and its familiarity with the states' institutional expertise that has developed over time, Congress seldom intrudes on the states' almost-exclusive domain in this regulatory sphere. And on those rare occasions when Congress determines that federal objectives must trump state regulatory efforts, Congress displaces state authority only as necessary to serve those specific objectives, otherwise leaving the states' regulatory powers intact. Congress's traditionally cautious approach has made assets of the states' greater insurance expertise and their greater sensitivity to local problems; both add critical oversight and accountability, and mitigate the potential conflicts that could otherwise arise from the implementation of Congress's federal objectives within the states' respective systems.

Congress employed this respectful approach in FEHBA's design. At the program's inception, Congress decided that FEHB carriers should submit fully to state regulatory authority. It later decided that preemption was necessary, but only upon realizing that FEHBA's goal of providing uniform benefits and coverage at affordable cost would be frustrated by state laws that mandated more than federal plans could provide. Even then, Congress targeted for preemption only those state laws causing the conflict. And Congress proceeded in a similarly limited fashion in amending FEHBA, when it expanded the FEHB program to allow certain managed-care arrangements, such as Preferred Physician Organizations (PPOs)—going no further than to preempt those specific state laws that would make such arrangements illegal.

Throughout these changes, deference to the states' superior capacities in regulating insurance remained Congress's guiding principle, and outside these narrow federal objectives, Congress left the states free to regulate FEHB carriers.

Congress intended for state restrictions on insurers' subrogation and reimbursement rights to fall within the wide swath of insurance-business regulation that Congress left to the states. These anti-subrogation laws were not mentioned among the list of specific state laws Congress slated for preemption when FEHBA's preemption provision was first enacted, and are different in kind from the laws on that list. Subrogation and reimbursement restrictions have no effect on the "benefits" or "coverage" the insurer promises to enrollees. They do nothing to absolve the insurer of its obligation to provide benefits. And the funds recovered through these processes bear absolutely no relationship to the insurers' initial benefits outlays, coming from a person completely outside the relationship between the government, insurer, and employee, and from sources that are kept separate from the insurers' initial outlays. And the recovered funds do not even necessarily go back to the insurers that paid out the initial benefits.

More fundamentally, however, the regulation of insurers' subrogation and reimbursement rights is reserved to the states because it implicates the federalist purpose lying at the heart of FEHBA's dual-regulatory design. Insurers' exercise of these rights has significant effects on the states' respective tort systems, and has serious implications for others outside the contractual insurance relationship, including injured employees, health-care provid-

ers, other creditors—and indeed, the tortfeasors themselves—all of whom might have competing claims to the same money. Deciding whether insurers' contractual subrogation and reimbursement rights should be enforced, or should instead give way to other priorities, requires carefully balancing these competing interests. Congress understood that the states' knowledge of their respective tort, insurance, and health-care systems, and the needs of the various players within each system, put the states in a better position to achieve the proper balance.

If any doubt existed about whether FEHBA's preemptive scope extended to state subrogation and reimbursement restrictions, it would have been better for OPM to have come to Congress to have those doubts dispelled. Over the course of the FEHBA's history, Congress has repeatedly demonstrated that it understands FEHBA's importance, and has proven time and again to be responsive to OPM's needs. On several occasions, OPM and its predecessors have come to Congress seeking additional powers. Congress has responded each time, granting the agencies the tools they needed to properly oversee and administer the program. Indeed, in other regulatory contexts, Congress has proven willing to go to even greater lengths than it did in FEHBA to craft preemption policy to fit agency needs—in some instances granting agencies the power to craft preemption policy *for themselves*, on a case-by-case basis. Congress has thus given every indication that it would have been willing to directly address section 8902(m)(1)'s preemptive effect on state anti-subrogation laws. Had it done so, OPM's position would stand on firmer constitutional footing.

ARGUMENT

I. Congress did not intend for FEHBA to preempt state restrictions on insurer subrogation and reimbursement rights.

State restrictions on insurers' subrogation and reimbursement rights existed long before Congress enacted FEHBA's preemption provision. And Congress was aware that these preexisting laws might apply to FEHBA plans. But Congress declined to include these laws within FEHBA's preemptive scope, deeming them to fall within the regulation of the business of insurance, a matter traditionally resting within the states' exclusive regulatory authority. Congress understood that FEHB carriers' exercise of their subrogation and reimbursement rights raises core federalism concerns, affecting different states in different ways, and Congress thought it better to allow the states to decide for themselves whether to allow these rights to be enforced, rather than grant FEHB carriers an exclusive right to shove aside all other comers at the tort-compensation trough.

A. Congress has left the states almost unfettered discretion to regulate private insurance.

For more than a century, insurance regulation has been dominated almost exclusively by the states, largely free from Congressional interference. John G. Day, Dep't of Transp., *Economic Regulation of Insurance in the United States* 10 (1970); Spencer L. Kimball, *Insurance and Public Policy* (1960); Kenneth J. Meier, *The Political Economy of Regulation: The Case of Insurance* 49-87 (1988).

Indeed, only once in our nation's history has state regulatory dominance over insurance been threatened, and that threat came from the Court, not Congress. In *United States v. South-eastern Underwriters Association*, 322 U.S. 533, 543 (1944), the Court threatened to federalize the business of insurance by determining it to be a matter of "interstate commerce," thus potentially within exclusive federal control under the Dormant Commerce Clause, *see* Martin H. Redish & Shane V. Nugent, *The Dormant Commerce Clause and the Constitutional Balance of Federalism*, 1987 Duke L.J. 569, 587-89 (1981). Congress reacted swiftly to this decision, to "restore the supremacy of the States in the realm of insurance regulation." *United States Department of the Treasury v. Fabe*, 508 U.S. 491, 500 (1993). It took less than a year for Congress to enact the McCarran-Ferguson Act, Pub. L. No. 79-15, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-15 (1994)), in which Congress declared that "the continued regulation and taxation by the several states of the business of insurance is in the public interest," 15 U.S.C. § 1011. And the Act "explicitly suspended Commerce Clause restraints on state taxation of insurance and placed insurance regulation firmly within the purview of the several States." *Metro. Life Ins. Co. v. Ward*, 470 U.S. 869, 884 (1985).[2]

During this period of virtually unfettered freedom, the states developed regulatory systems that today provide critical oversight of private insurance companies. All

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[2] The McCarran-Ferguson Act provides, in relevant part, that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, *** unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b).

states have laws licensing insurance companies, agents, and brokers. *Exemption of Federal Employees Health Benefits Program from Certain State Laws on H.R. 12114 Before the Subcomm. on Retirement and Emp. Benefits of the H. Comm. on Post Office and Civil Servs.*, 94th Cong. 40 (1976) (statement of Dick L. Rottman, President of the National Association of Insurance Commissioners (NAIC) (Hearing No. 94-69); see, e.g., NAIC, *Model Laws, Regulations, and Guidelines* (NAIC *Model Law*) § MDL-218 (Producer Licensing Model Act); *id.* § MDL-228 (Public Adjustor Licensing Model Act); *id.* § MDL-220 (Prevention of Illegal MEWAs & Other Illegal Health Ins. Model Regulation). States secure insurer solvency by mandating minimum reserves and requiring sound financial and reporting practices. Hearing No. 94-69, at 40. States have also enacted legislation to prevent insurers from engaging in unfair marketing and claims-handling practices. *Id.* at 40-41; e.g., NAIC Model Law § MDL-880 (Unfair Trade Practices Act); *id.* § MDL-900 (Unfair Claims Settlement Practices Act). And states have sought to ensure the availability of affordable insurance coverage by setting rates and policy terms. See generally Robert H. Jerry, II, *Understanding Insurance Law* 22 (2d ed. 1996); Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 Minn. L. Rev. 471, 482 (1961). The states enforce these regulatory commands through their own specialized regulatory bodies, armed with broad enforcement powers, and also by permitting civil actions against insurers in court. Hearing No. 94-69, at 41.

State dominance in insurance regulation is due, in part, to Congress's respect for the sovereignty that the states

possess "'concurrent with that of the Federal Government,'" *Gregory v. Ashcroft*, 501 U.S. 452, 457 (1991) (quoting *Tafflin v. Levitt*, 493 U.S. 455, 458 (1990)), and the recognition that insurance is one of the "areas of traditional state regulation" that Congress does not lightly tamper with. *Metro. Life Ins. v. Mass. Travelers Ins. Co.*, 471 U.S. 724, 740 (1985); see *id.* at 741; *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 19 (1987).

State dominance of insurance regulation also reflects Congress's understanding that the states possess special competence in insurance regulation that the federal government lacks. State legislators and regulators have developed relationships with the people and institutions impacted by their actions—including insurers, consumers, and, in the case of health insurance, health-care providers. Ronald Gift Mullins, *Strong Congressional Debate Role Urged for Industry Regulators*, J. Com., June 11, 1997 at 8A (quoting Josephine Musser).

The states' smaller geographic sphere of responsibility also enables them to provide closer, more personalized oversight, tailored to local assumptions, local problems, and individual communities' needs. NAIC, *1995 NAIC Annual Report* 15 (1996) ("[T]he states are closer to the consumers they are protecting and the industry they are regulating," which is why "states do a better job of regulating insurance than the federal government could."). And local expertise matters, because the insurance business has numerous "logical ties to the geographic, economic, and political structures of the states," that affect employers, health-care providers, and others. Hearing No. 94-69, at 43.

Recognizing these realities, Congress has consistently

sought to make use of state regulatory expertise in fashioning federal legislation regarding private insurance. Even where Congress has identified areas of "exclusive federal concern," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990), or where "distinctly federal interests" are at play, *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 696 (2006), and determines it necessary to take over important areas of insurance regulation—whether to offer affordable comprehensive insurance to seniors, to expand health care access to all Americans, or to completely overhaul the regulation of employee benefit plans—Congress has still left the states with significant regulatory authority. And the unblemished core of that authority has always included the states' power to regulate the business practices of carriers that wanted to do business in their respective states.[3]

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[3] E.g., Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 232(a)(3), 117 Stat. 2066 (subjecting private Medicare plans to "State licensing laws or State laws relating to plan solvency," 42 U.S.C. § 1395w-26(b)(3), a directive that the Centers for Medicare & Medicaid Services has interpreted to include "[s]tate environmental laws, laws governing private contracting relationships, tort law, labor law, civil rights laws and similar laws, Dep't of Health & Human Servs., Ctrs. For Medicare & Medicaid Servs., *Medicare Prescription Drug Benefit*, 69 Fed. Reg. 46,632, 46,696 (Aug. 3, 2004)); Patient Protection and Affordable Care Act, Pub. L. No. 11-148, § 1321(d), 124 Stat. 119 (2010) (PPACA) (providing that "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title"); Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, § 514(b)(2)(A), 88 Stat. 829 (ERISA) (preserving any state law that "regulates insurance," 29 U.S.C. § 1144(2)(A), which "reserv[es] the business of insurance to the States," *Metro. Life*, 471 U.S. at 744 n.21).

B. FEHBA's dual-regulatory regime preserves the states' authority to regulate FEHB carriers' business practices.

Congress followed this tried-and-true dual-regulatory formula with FEHBA, striking a balance of federalism particularly slanted in favor of state regulatory authority. Congress extended FEHBA's preemptive reach to laws that would interfere with FEHB plan terms relating to "benefits" or "coverage." But Congress has left intact the states' authority to regulate *everything* else.

1. The Federal Employees Health Benefits Act of 1959.

When Congress first created the Federal Employee Health Benefit Plan in 1959, Pub. L. No. 86-382, 73 Stat. 708, to offer health benefits to federal employees, it sought to close a "wide gap" that existed between the "government, in its capacity of employer, and employers in private enterprise," that "almost universally" offered "contributory health benefit programs." H.R. Rep. No. 86-957, at 1-2 (1959); J.A. 267a-268a. It sought to provide those health benefits in the same manner as private employers did, by "execut[ing] contracts" with private insurance carriers to administer FEHB plans, 5 U.S.C. § 8902(a); H.R. Rep. No. 86-957, at 3; J.A. 269a.

Congress viewed the state's ability to provide accountability and consumer protection as an important asset in this new program—which is unsurprising, given that the federal government was becoming a consumer of insurance. Accordingly, Congress did not "design[]" FEHBA to "regulate the insurance business" or to "override any state regulatory scheme." Report of the Comptroller General of the United States, B-164562, *Conflicts Between*

State Insurance Requirements and Contracts of the Federal Employees Health Benefit Carriers 15 (1975) (Comptroller General Report). Rather, because Congress recognized that "[a]ll states regulate the health insurance business in various" ways, S. Rep. No. 95-903, at 7 (1973); J.A. 375; Hearing No. 94-69, at 3 (Statement of Thomas Tinsley, Director, Bureau of Retirement, Insurance, and Occupational Health) (same), it left to the states "the authority to both regulate and tax health insurance carriers operating under the [FEHB] program," in the same manner that they regulated other private insurers. Comptroller General Report at 15.

2. The Civil Service Reform Act of 1978.

In the "early years of the" FEHB program, subjecting the FEHB carriers to the states' complete regulatory authority "offered few if any problems." S. Rep. 95-903, at 7; J.A. 375. But in the early 1970s, certain FEHB carriers encountered state laws that conflicted with the provisions in their plans. Comptroller General Report at 2-4. These "presented serious problems" for the program. S. Rep. 95-903, at 7; J.A. 375. Complying with them would mean additional premium costs, which would make the program more expensive for "both the Government and enrollees," H.R. Rep. No. 94-1211, at 3 (1976); J.A. 338. It also threatened the "uniformity of benefits" the government had promised to enrollees. *Ibid.* Some employees would get "benefits for which they did not contract," Hearing No. 94-69, at 2 (Statement of Thomas Tinsley), and others would end up "paying a premium based, in part, on the cost of benefits provided only to enrollees in other States." H.R. Rep. No. 94-1211, at 3; J.A. 338; see also S. Rep. 95-903, at 9; J.A. 379. This lack of uniformity was not only inequitable, but also put "carriers in serious jeopardy" of losing

their eligibility to provide insurance under the plan, S. Rep. 95-903, at 7; J.A. 376, because eligible carriers are required to be "licensed to issue group health insurance in all the States and the District of Columbia," see 5 U.S.C. § 8902(a) & (b), and thus an insurer's failure to follow even one state's law could force it out of the FEHB program entirely, S. Rep. 95-903, at 7; J.A. 376.

In keeping with its traditional respect for state insurance regulation, Congress took a targeted approach in addressing these conflicts. Congress first decided to act in February of 1975, after certain FEHB insurers had come to the Civil Service Commission (CSC) expressing concern about the impact that state-mandated benefit laws were having on their plans. H.R. Rep. No. 95-282, at 3 (1977); J.A. 353-54; Comptroller General Report at 13-15. In response, the Honorable Richard C. White, Chairman of the House Subcommittee on Retirement and Employee Benefits, requested the Comptroller General of the United States to furnish a report identifying "those State health insurance requirements which conflict with contracts negotiated between the FEHB carriers and the Civil Service Commission." H.R. Rep. No. 94-1211, at 2; J.A. 336; Comptroller General Report at 18-19, App. I. Representative White also asked the Comptroller to study the costs that would be incurred if FEHB plans were "changed to include all benefits" that enrollees were entitled to receive by state statute. Comptroller General Report at 19, App. I.

In response, the Comptroller, with the assistance of AETNA, one of the FEHB carriers, identified a set of 19 specific "[s]tate insurance laws, regulations, and Attorney's generals opinions" in 14 states that "conflict with contracts" of the FEHB carriers. Comptroller General

Report at 1, 5, 24. These included state mandates for health insurance carriers to cover chiropractic services, acupuncture, and treatment for mental illness and alcoholism, along with laws that mandated continuation of coverage, home health care, and maternity benefits. Comptroller General Report at 5-12, 21-24. One law from Maryland even mandated that health-insurance carriers cover benefits that might otherwise be provided under no-fault automobile insurance. *Id.* at 24. The Comptroller General estimated that premiums might have to increase by "as much as 5 percent" to cover the benefits mandated for the enrollees in these states, H.R. Rep. No. 95-282, at 4; J.A. 355; see Comptroller General Report at iii, 18.

Accordingly, when Congress decided to amend FEHBA to add a preemption provision, it did so as a "direct result" of the Comptroller General's Report, Hearing No. 94-69, at 1, based on a detailed legislative record tied specifically to these laws.

The preemptive effort that resulted from this narrow, targeted investigative effort was likewise narrow and targeted. The CSC, the agency charged with implementing FEHBA at the time, did not request "complete preemption" of all state laws that might impact the plans. H.R. Hearing No. 94-69, at 4. And Congress provided only "a form of limited preemption," S. Rep. 95-903, at 7; J.A. 375, which targeted "the various State conflicts" outlined in the Comptroller General Report, H. R. Rep. No. 94-1211, at 2; J.A. 336.

As the Committee reports and hearing transcripts from this legislative effort reveal, Congress's sole objective in enacting FEHBA's preemption provision, 5 U.S.C. § 8902(m)(1), Act of Sept, 17, 1978, Pub. L. No. 95-368, 92

Stat. 606, was "to establish uniformity in benefits and coverage," and the only state laws and regulations it sought to preempt were "State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts." H.R. Rep. No. 95-282, at 6; J.A. 359. Congress thus targeted laws that would conflict with FEHB contractual provisions concerning "the nature or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1) (1982). But Congress made clear that in doing so, it was pulling out only isolated pieces of the states' regulatory authority. State laws were preempted only "insofar as they pertain to benefits and coverage." H.R. Rep. No. 95-282, at 6; J.A. 359. To Congress, this meant that section 8902(m)(1)'s preemptive scope would reach:

> State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage when such laws or regulations conflict with the provision of contracts under" the FEHBP.

H.R. Rep. 94-1211, at 4; J.A. 339; H.R. Rep. No. 95-282, at 4-5; J.A. 356-57—a list that was virtually identical to the list of laws regarding "benefits" compiled in the Comptroller General's Report. Comptroller General Report at 1. But according to Congress, "such a preemption" was "purposely limited," and would not "provide insurance carriers under the program with exemption from state laws and regulations governing other aspects of the insurance business, such as the payment of premium taxes and requirements for statutory reserves." H.R. Rep. No. 95-282, at 6;

J.A. 359. As Senator Herbert Harris explained, the provision "limits itself solely to who is eligible for this Federal plan and what benefits are provided," and he cautioned: "I think we ought to make sure we don't get into the business of just overriding willy-nilly today or in the future the State's rights as far as the regulation of the industry is concerned." Hearing No. 94-69, at 14.

3. The Federal Employees Health Care Protection Act of 1998.

When Congress amended FEHBA's preemption provision in the Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (FEHCPA), it again had narrow goals in mind, and tailored its amendments to those specific aims. Congress moderately expanded upon section 8902(m)(1)'s preemption provision in two ways. The first addressed a series of cases in which courts had permitted claimants to skirt preemption of state tort claims by arguing they merely augmented the duties in the plans, and were thus not "inconsistent" with the plans. Brian Harr, *Legislative Reform: FEHBA's Preemption Clause: Is It a Model for Private Employers' Subsidized Health Care?*, 22 J. Legis. 267, 273 (1996) (discussing *Eidler v. Blue Cross Blue Shield United of Wisconsin*, 671 F. Supp. 1213, 1216-17 (E.D. Wis. 1987)). Congress deleted the language from section 8902(m)(1) that required a state law to be "inconsistent" with FEHB contract terms to be preempted, "thereby giving the federal contract provisions clear authority" over state law when those terms concerned benefits or coverage. S. Rep. No. 105-257, at 15 (1998); J.A. 468.

Congress also revised FEHBA' preemption provisions as part of a larger effort within the Federal Employees

Health Care Protection Act to encourage "managed care programs," H.R. Rep. No. 105-374, at 16 (1997); J.A. 416-17, such as PPOs, in which insurers enter contractual arrangements with providers to offer their services at discounted rates. Congress found these arrangements to provide "legitimate and valuable benefits" in the form of cost savings to "health care providers, carriers, and patients," S. Rep. 105-257, at 3; J.A. 444. Congress determined that allowing these arrangements would "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9; J.A. 403.

Permitting these PPO arrangements required preempting "State-mandated 'any-willing provider' statutes," *ibid.*, to the extent they applied to FEHBA plans. Such "any-willing provider" laws give plan beneficiaries the right to select their own health-care provider, and to require their insurance carrier to pick up the cost of the provider's services, on the same terms with doctors in the plan's network. Nat'l Conf. of State Legislatures, *State Roles in Health Reform Provisions Related to Insurance* (Oct. 2011), <http://bit.ly/2ibvq8I>. This obviously hampered efforts to create PPO network arrangements. To prevent these "cost-cutting initiatives from being frustrated" by these "any-willing-provider" laws, H.R. Rep. No. 105-374, at 9; J.A. 403, Congress expanded section 8902(m)(1)'s preemptive scope to include not only contract terms relating to the "nature or extent of coverage or benefits," but also those relating to the "provision" of "coverage or benefits." 5 U.S.C. § 8902(m)(1). This change targeted for preemption laws that limited the "types of organization [that] can *provide* health care," S. Rep. No. 105-257, at 14-15 (emphasis added); J.A. 468, thus displacing

state laws that would not allow plans that "provide[d]" benefits through such "managed care programs," H.R. Rep. No. 105-374, at 16; J.A. 416-17.

Congress took pains to explain that this was only a very limited expansion of section 8902(m)(1)'s preemptive scope. The Senate's report specified that the change would only "affect states that have requirements governing what types of organization can provide health care when those requirements are different from those under federal contracts." S. Rep. No. 105-257, at 14-15; J.A. 468. The amendments thus had no effect on state regulations concerning the business of FEHB insurers more generally.

Taken together, these benchmarks in FEHBA's development demonstrate that Congress understood the preemptive scope of section 3902(m)(1) to be quite limited, in keeping with Congress's traditional respect for state insurance regulation. And these acts show the care that Congress took in its preemption policy, displacing states' authority no further than necessary to achieve the specific objects it had in mind.

For instance, on more than one occasion, Congress has stressed the need to control costs as reason to amend FEHBA's preemptive scope—whether to avoid cost *increases* that would result from state-mandated benefits laws, H.R. Rep. No. 94-1211, at 3; J.A. 338, and the administrative costs of complying with differing state laws, *ibid.*, or to promote cost *savings* by lifting restrictions on the types of organizations that could provide insurance, H.R. Rep. No. 105-374, at 9; J.A. 403. But Congress's desire for cost-savings did not mean that it intended to provide FEHBA carriers with free-form immunity from any state law that impact plan costs. After all, Congress explained

that state laws regarding "premium taxes" were not to be preempted, H.R. Rep. No. 95-282, at 6; J.A. 359, despite its awareness that allowing the states to impose such taxes added millions of dollars to the costs of the plans, up to $13 dollars per enrollee for some plans, Comptroller General Report at 20, App. II, and subjected the plans to the administrative costs of complying with the tax laws of 50 different states.

Likewise, the fact that Congress sought to provide uniformity in benefits and coverage through section 8902(m)(1), H.R. Rep. No. 94-1211, at 3; J.A. 337, did not mean that it intended the "administration" of FEHB plans or benefits to be perfectly uniform. *Burkey v. Gov't Emp. Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993); OPM, Proposed Rule, *Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 932, 933 (Jan. 7, 2015) (Proposed Rule). Congress sought uniformity in benefits and coverage within plans because that was what it promised to employees, H.R. Rep. No. 94-1211, at 3; J.A. 337. But in areas *other* than benefits or coverage, Congress was willing to bear the increased administrative burden of a federalist system, because those costs were outweighed by the benefits of oversight and localized decision-making that came with leaving the large part of the regulation of FEHB carriers to the states.

C. FEHBA carriers' subrogation and reimbursement rights concern insurance business practices that Congress reserved to the states.

State restrictions on subrogation are among the regulations regarding the business of FEHB insurers that

Congress intended to remain within the province of the states after enactment of section 8902(m)(1). This conclusion follows not only from the absence of any relationship between these laws and the "benefits" or "coverage" of FEHB plans, 5 U.S.C. § 8902(m)(1), but also because state regulation of these insurer rights is necessary to fulfill the basic federalist purpose behind FEHBA's dual-regulatory structure.

1. Subrogation and reimbursement restrictions are not among the specific state laws Congress targeted for preemption.

Subrogation and reimbursement provisions have long been common in insurance contracts, and OPM's "longstanding practice" has been for "FEHB Program contracts and the applicable statement of benefits" to "require carriers to seek reimbursement and/or subrogation recoveries." Proposed Rule, 80 Fed. Reg. 931, 933. Even before FEHBA's preemption provision was enacted, many states, including Missouri, refused to enforce these contractual rights of insurers. *Jones v. Aetna Casualty & Sur. Co.*, 497 S.W.2d 809, 812 (Mo. App. 1973) ("[A]n insurer may not acquire part of the insured's rights against a tortfeasor (other than an uninsured motorist) by reason of payment of medical expense, *either by assignment or by subrogation.*") (emphasis added). See also, e.g., 36 Okl. St. Ann. tit. 36, § 6092 (1971) (imposing "[l]imitations on subrogation and setoff under medical coverage"); Kan. Admin. Regs. § 40-1-20 (1966) (prohibiting subrogation clauses "for certain coverages"); *State Farm Fire & Cas. Co. v. Knapp*, 484 P.2d 180 (Ariz. 1971) (refusing to permit subrogation as an impermissible assignment of a personal injury claim); *Berlinski v. Ovellette*, 325 A.2d 239 (Conn. 1973) (invaliding subrogation provision in an automobile-

insurance contract), overruled in *Westchester Fire Ins. Co. v. Allstate Ins. Co.*, 236 Conn. 362 (1996), overruled by statute, C.G.S. 38a-336b (denying insurers that provide uninsured-motorist coverage any right of subrogation against uninsured motorists); *Fifield Manor v. Finston*, 354 P.2d 107 (Ca. 1960); *State Farm Fire & Cas. Ins. Co. v. Farmers Ins. Exch.*, 489 P.2d 480 (Okl. 1971); *Wrightsman v. Hardware Dealers Mut. Fire Ins. Co.*, 147 S.E.2d 860 (Ga. 1966).

Congress was thus doubtless aware of these state anti-subrogation regulatory efforts when it passed section 8902(m)(1) into law, and thus understood that these restrictions might have an impact on FEHB plan terms. But these laws were not among "the various State conflicts" that Congress sought to preempt with section 8902(m)(1), H. R. Rep. No. 94-1211, at 2; J.A. 336, although, at the time, these anti-subrogation laws were far more pervasive than the state-mandated benefits laws that were targeted for preemption. Anti-subrogation laws likewise go unmentioned in all of the committee reports and hearing testimony surrounding adoption and amendment of section 8092(m)(1). This complete absence of Congressional attention demonstrates that Congress has not "in fact faced" the question of whether FEHBA's preemptive reach extends to state restrictions on insurers' subrogation and reimbursement rights, reason alone to conclude that Congress did not intend to intrude into this "traditionally sensitive area[]" of "the federal balance" between federal and state authority. *United States v. Bass*, 404 U.S. 336, 349 (1971).

2. Subrogation restrictions bear no relation to benefits or coverage as Congress understood them.

State restrictions on subrogation and reimbursement also bear no relationship to "benefits" or "coverage," as required for preemption under section 8902(m)(1). In *McVeigh*, the Court expressed concern about the "puzzling" nature of section 8902(m)(1), concluding that its provisions were ambiguous and subject to multiple "plausible constructions." 547 U.S. at 697-98. But when Congress enacted section 8902(m)(1), it did not understand these terms to be ambiguous, nor did it understand them to encompass state restrictions on subrogation and reimbursement.

Anti-subrogation laws have no connection to "coverage" as Congress used the term in section 8902(m)(1), because in that provision, Congress adopted an industry definition of that term—using it to refer to "who is eligible to participate," Hearing No. 94-69, at 14 (Statement of Peter Connell, Counsel, AETNA Life & Cas.), "and for how long," *id.* (Statement of Daniel W. Pettengill, Vice President, Group Div., AETNA Life & Cas.).[4] There is no question that restrictions on subrogation and reimbursement

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[4] References within the contemporaneous committee reports are consistent with Congress's adoption of this industry view. E.g., H.R. Rep. No. 95-282, at 1, J.A. 351 (providing that FEHBA provides "health insurance coverage for about 3 million Federal employees and annuitants and 6 million dependents); *id.* at 4, J.A. 356 (referring to "coverage of family members"); *id.* at 6, J.A. 360 (noting that the problems giving rise to section 8902(m)(1) began when states started mandating, among other things, the "family members to be covered, the age limits for family members, [and] extension of coverage").

rights have nothing to do with these aspects of the insurance relationship.

These laws do not have any connection to contractual "benefits" either. Not only are state restrictions on reimbursement or subrogation completely absent from the list of laws concerning "benefits" compiled in the Comptroller General's 1975 report, Comptroller General Report at 1, they are also different in kind from those included on that list. Each of the laws listed in the Comptroller General's Report relate to, and dictate, the "benefit structure" of the plan itself—the benefits initially given to plan enrollees. Hearing No. 94-69, at 4 (Statement of Thomas Tinsley).

Restrictions on subrogation or reimbursement, on the other hand, do not fit within this conception of benefits. They neither dictate nor constrain the insurer's obligation to provide benefits—which remains unchanged regardless of whether the insurer becomes entitled to a recovery later or not. And the cost-recovery mechanisms that these laws regulate are entirely distinct from the underlying benefits that create the reimbursement obligation. Indeed, the later-in-time recoveries they provide never actually come out of the benefits that were initially provided by the insurer, see 5 C.F.R. § 890.101(f) (providing that payments to the insurer must come "out of the recovery" from a third-party). This is because these funds are not retained by the enrollee, but instead go to health-care providers that are under no obligation to pay them back.

Indeed, funds recovered via subrogation or reimbursement under FEHB plans do not even necessarily go back to the same insurer that paid out the benefits in the first place. Some recoveries are "required to be credited to the Employees Health Benefits Fund established by 5 U.S.C. § 8989, held by the Treasury of the United States," which

is controlled by OPM, not the insurers. OPM Proposed Rule, 80 Fed. Reg. 932; FEHB Program Carrier Letter No. 2012-18, Pet. App. 117a.

Accordingly, restrictions on subrogation and reimbursement, like the contractual rights they regulate, bear no relationship to benefits. Instead, they are more akin to laws mandating "statutory reserves," H.R. Rep. 95-282, at 6; J.A. 359, targeting the operating funds that insurers to *pay* benefits, which Congress decided do not "relate to" the "nature, provision, or extent of coverage," and thus fall within the laws relating to the "business of insurance" that Congress reserved to the states. 5 U.S.C. § 8902(m)(1).

3. Principles of federalism favor leaving regulation of subrogation and reimbursement rights to the states.

Preemption of subrogation and reimbursement restrictions would not only be inconsistent with FEHBA's statutory text, it would also disregard Congress's core federalist purpose behind its decision in FEHBA to leave matters regarding the business of insurance to the states. This is because subrogation and reimbursement rights do not exist in isolation. These contractual rights can have larger impacts on states' tort systems. For example, in some jurisdictions, the "double recovery" that an insured might receive as the result of restrictions on subrogation might not be seen as a windfall, but instead as a trade-off for stricter limits on tort remedies. Accordingly, stripping away those restrictions might deprive injured parties of compensation that is necessary to make them whole. Moreover, insurers are not the only ones who rely on tort recoveries to recover costs. Injured parties, health care providers, and other creditors may all have competing claims to the money coming from the tortfeasor, and the

tortfeasor herself may claim a right to retain that money. State regulators are in a better position than Congress to know whether allowing subrogation recoveries will upset the balance of these other interests within their respective health-care, insurance, and tort systems, and are in a better position to prioritize the competing interests involved in tort recoveries. This is a compelling reason why Congress intended for the matter of subrogation to be left to the states, not subjected to a single, inflexible, uniform federal rule.

Subrogation and reimbursement restrictions are also divorced from the other concerns that motivated Congress to create, and then amend, FEHBA's preemption provision. Restrictions on subrogation and reimbursement rights raise no risk of cross-subsidies—"paying a premium based, in part, on the cost of benefits provided only to enrollees in other States," H.R. Rep. No. 94-1211, at 3; J.A. 338—that motivated Congress to universalize coverage and benefits through preemption. Whether injured parties are entitled to keep funds they receive based on duties entirely exterior to the insurance contract, from people who are not covered under the insurance contract, and who themselves are not receiving benefits under the contract, has no potential to create inequity—either in the premiums employees are forced to pay, or in the resulting benefits they are entitled to receive.

There is likewise no indication that an attempt to assert subrogation or reimbursement rights in contravention of state law will put "carriers in serious jeopardy" of losing their eligibility to provide insurance under FEHBA, S. Rep. 95-903, at 7; J.A. 376. Indeed, Coventry

has asserted its subrogation rights, and there is no indication that it is at risk of forfeiting its Missouri insurance license for doing so.

4. Promoting parity between the preemptive scopes of ERISA and FEHBA does not counsel in favor of preemption, but against.

Finally, it is often suggested that FEHBA and ERISA should be read together, *Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294, 299 n.2 (1st Cir. 2005) (per curiam), *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002); see also, e.g., *Aybar v. N.J. Transit Bus Operations, Inc.*, 701 A.2d 932, 935-36 (N.J. App. Div. 1997), to ensure that federal employees "receive equal treatment with private-sector plans governed by ERISA." Pet. Br. at 12. It is also argued that adopting this principle of parity would cause subrogation and reimbursement restrictions to be preempted under this Court's decision in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

But ERISA's preemption provision, which "proport[s] to render inoperative any and all state laws that in some way bear on federal *employee-benefit plans*," *McVeigh*, 547 U.S. at 698 (citing 29 U.S.C. § 1144(a)), is materially broader than FEHBA's, which targets only those terms *within* a plan relating to "benefits" and "coverage," 5 U.S.C. § 8902(m)(1). These critical differences make it doubtful that Congress actually intended for them to be read together.

But in any event, any pursuit of parity between ERISA and FEHBA *should* require reading FEHBA's preemption provision narrowly, to preserve state authority to regulate insurers' subrogation and reimbursement rights.

This is because ERISA's savings clause, like FEHBA's preemption clause, preserves an essential role for the states in regulating "the business of insurance," 29 U.S.C. § 1144(b)(2)(A), *Metro. Life*, 471 U.S. at 744 n.21, which this Court held "returns the matter of subrogation to state law," *Holliday*, 498 U.S. at 61. If subrogation is a matter reserved to the states under ERISA, then parity would require that the issue should also be left to the states under FEHBA.

Indeed, although the state anti-subrogation restriction at issue in *Holliday* fell outside the coverage of ERISA's savings clause in section 514(b)(2)(A), that result had nothing to do with the nature of the state law at issue in *Holliday*. It hinged instead on specifics about nature of the *plan* at issue in that case. There was no question that the anti-subrogation restriction at issue in *Holliday* was a "State law[] that directly regulat[ed] insurance," *Holliday*, 498 U.S. at 61, and thus within ERISA's "saving clause." Instead, the reason that the law was not "saved" had to do with a different part of ERISA—the "deemer clause," *ibid.*, 29 U.S.C. § 1144(b)(2)(A). Under this "deemer clause," the self-funded employee benefit plans at issue in *Holliday* were not "deemed to be an insurance company" or "to be engaged in the business of insurance," and thus were exempt from the state laws regulating "insurance" that were saved from preemption under ERISA section 514(b)(2)(A). 498 U.S. at 61. As this Court noted, this "deemer" clause existed because "requir[ing] plan providers to design their programs in an environment of differing state regulations *** complicat[es] the administration of nationwide plans," *Holliday*, 498 U.S. at 60, and Congress considered this task, and its administrative

costs, to be too much for normally smaller self-funded and self-insured plans to bear.

The outcome in *Holliday* thus depended upon the plan at issue, and illustrates nothing beyond Congress's intent to exempt very small self-insured plans from being forced to deal with the administrative burdens of applying with the varying laws of different states. But the FEHB program contains no equivalent to the self-insured plans at issue in *Holliday*. FEHB carriers must be large enough to be licensed in all 50 states and DC before they are qualified to offer FEHBA plans, and thus Congress understood that they would be already accustomed to modifying their administrative practices to comply with the varying laws of different jurisdictions.

Thus, putting the federal and private employees of Missouri and other states on equal footing (except for the small-subset in self-insured plans) would require respecting state protections against preemption, not preempting them.

II. OPM would have been better served asking Congress to explicitly preempt state regulation of insurers' subrogation and reimbursement rights.

If the past 60 years since the creation of the FEHB program have taught anything, it is that Congress has always understood the program to involve important interests, and has proven remarkably responsive to the needs of the agencies charged with running the program.

The 1959 reforms that led to the FEHBA were recommended by the CSC (the agency charged with administering the statute at that time), which thought the reforms "highly desirable." H.R. Rep. 86-957, at 18; J.A. 301. And

when Congress added FEHBA's preemption provision, it came after CSC "strongly urged" Congress to amend FEHBA to address laws that conflicted with plan terms. H.R. Rep. No. 95-282, at 6; J.A. 359; Comptroller General's Report at 13-15. CSC insisted that preemption was in the best interest of the plan, and would enable the Commission to "administer the [FEHB] in a reasonable and efficient manner." H.R. Rep. No. 95-282, at 3; J.A. 354-55. Congress thus provided CSC with exactly the preemptive power it requested.

When Congress later amended FEHBA's statutory provisions, at the insistence of OPM and others, it "provide[d] the Office of Personnel Management" (which had taken over administration of the FEHB) with substantially greater powers, giving it new ways to "fight[] waste, fraud, and abuse," H.R. Rep. 105-374, at 6; J.A. 398, "reduce administrative burdens" on OPM, *id.* at 15; J.A. 469, offer PPO plans, and expand the types of underwriting organizations that OPM could use as carriers, *id.* at 9; J.A. 456. Congress has thus repeatedly proven itself to be responsive to OPM's requests, and has consistently acted to give the agency the tools it needs to make the FEHB program operate as efficiently and effectively as possible.

Indeed, in other regulatory contexts, Congress has demonstrated even greater willingness to allow agencies to have a hand in crafting preemption policy. For instance, Congress has given the Secretary of Defense enormous power to preempt state laws in the implementation of the CHAMPUS Program, which allows military personnel and their dependents to access civilian health services in a program akin to an employer-provided health-care plan. Anderson et al., RAND Corp., Nat'l Def. Res. Inst., *Eval-*

uation of the CHAMPUS Reform Initiative, Vol. 6: Implementation and Operation 3-4 (1994). When Congress first explored the idea of using managed-care arrangements in CHAMPUS to control costs, it created a pilot program in two states, and granted blanket preemption of "State and local laws and local laws and regulations" for the provisions in the initial managed-care contracts in that pilot program. H.R. Rep. No. 103-200, 1993 WL 298896, at *298 (1993); see National Defense Authorization Act for Fiscal Year 1987, Pub. L. No. 99-661, § 701-703, 100 Stat. 3816 (1986); 10 U.S.C. § 1103(a) (1988).

But at the close of the Cold War, when the resulting draw-down in military personnel reduced the number of active-duty military physicians, Congress anticipated that the DOD would begin "moving toward greater reliance on [private] contractor support for the delivery of health care services" within CHAMPUS, H.R. Rep. No. 103-200, 1993 WL 298896, at *298, by expanding these managed-care programs. Congress decided that preemption should be relaxed for these new managed-care programs, "believ[ing] that State and local government regulation of health plans operating within their purview generally provides added protection," H.R. Rep. No. 103-200, 1993 WL 298896, at *298. Accordingly, in a provision of the National Defense Authorization Act for Fiscal Year 1994, Pub. L. No. 103-160, § 715, 107 Stat. 1547, 1642 (1993), Congress provided that any state or local law that conflicted with CHAMPUS terms would be preempted "to the extent that the Secretary of Defense" decided that such law was "inconsistent with a specific provision in a contract or regulation," or determined that preemption is "necessary to implement or administer the provisions of the contract or to achieve any other important Federal Interest." 10

U.S.C. § 1103(a); H.R. Rep. No. 103-200, at *193. This gave considerable discretion to the Secretary of Defense to decide selectively, on a case-by-case basis, whether state law should give way to CHAMPUS plan terms, or vice-versa, and shows the lengths Congress will go—indeed, far farther than FEHBA—to craft preemption policy to fit specific agency needs.

Accordingly, if OPM felt that the scope of federal preemption needed to be expanded or clarified, it should have made its case to Congress, and Congress would have addressed the question directly. That would have been the better path, and would have ensured that preemption was actually what Congress intended.

CONCLUSION

The judgment of the Missouri Supreme Court should be affirmed.

Respectfully submitted,

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In the Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,
fka Group Health Plan, Inc.,
Petitioner,

v.

JODIE NEVILS,
Respondent.

On Writ of Certiorari to the Supreme Court of Missouri

BRIEF OF MONTANA, ALABAMA, ALASKA, COLORADO, ILLINOIS, INDIANA, IOWA, KANSAS, LOUISIANA, MICHIGAN, NEBRASKA, NEVADA, NEW HAMPSHIRE, OHIO, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, WEST VIRGINIA, AND WYOMING AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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INTEREST OF THE AMICI CURIAE

"As every schoolchild learns, our Constitution establishes a system of dual sovereignty between the States and the Federal Government." *Gregory v. Ashcroft*, 501 U.S. 452, 457 (1991). The amici States, as separate sovereigns within the federal system, have important interests in the outcome of this case. As sovereigns, we have the responsibility to enforce our laws to safeguard the welfare of our citizens. In fulfilling this role, and as a matter of federalism, the States have an interest in preserving the appropriate balance between the authority that the federal government exercises and the authority that the States exercise.

Of significant concern to the amici States are cases involving the preemption of state laws by federal agencies. The States recognize that, in some circumstances, agency regulations with the force of law can preempt state law. In our view, however, absent a delegation from Congress, federal agencies are not entitled to deference when they opine, even through notice-and-comment rulemaking, about the preemptive scope of federal law.

While states have representation in Congress, they have no representation in federal agencies. If agencies are allowed to preempt state laws when Congress has not delegated them that authority, then the States' sovereign interests are not protected, the principles of federalism are not honored, and agencies can increase their power by using simple rulemaking to displace state laws. The amici urge this Court to affirm the decision of the Missouri Supreme Court and to hold that federal agencies are not entitled to deference when

they opine about the preemptive scope of federal law, particularly when Congress has not delegated to the agency the authority to preempt state law.

STATEMENT OF THE CASE

The Federal Employee Health Benefits Act (FEHBA) governs health insurance benefits for federal employees. In FEHBA, Congress authorized the Office of Personnel Management (OPM) to manage the program, issue regulations, and contract with insurance carriers to administer FEHBA plans. *See, e.g.*, 5 U.S.C. §§ 8902, 8909, 8913. FEHBA contains an express-preemption clause, which states that contract terms "relat[ing] to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). While FEHBA contains an express-preemption provision, it does not contain a provision expressly authorizing OPM to make preemption determinations.

Respondent Jodie Nevils was a federal employee who was injured in a car accident, and Coventry, or its predecessor, paid for his care. Pet. App. 45a. After Nevils recovered a tort settlement from the third party responsible for the accident, Coventry sought reimbursement and asserted a lien for the amounts it had paid. *Id.* Nevils satisfied the lien and then sued Coventry in state court based on Missouri law, which does not permit the subrogation of tort claims. *Id.*

When the case reached the Missouri Supreme Court, the sole issue concerned whether FEHBA

preempted Missouri's anti-subrogation law. Pet. App. 46a. The Missouri Supreme Court explained that preemption analysis is "informed by two presumptions": "First, it is presumed that the states' historic police powers are not preempted unless it is the clear intent of Congress"; and, second, the scope of a preemption provision depends on Congress's purpose in enacting the statute. Pet. App. 47a-47b. The Court noted that, when interpreting a statute with more than one plausible reading, courts have a "duty to accept the reading that disfavors pre-emption." Pet. App. 47b (quoting *Bates v. Dow AgroSciences, LLC*, 544 U.S. 431, 449 (2005)).

The Missouri Supreme Court recognized that it was not the first to consider FEHBA's preemption provision. In *Empire HealthChoice Assurance Inc. v. McVeigh*, 547 U.S. 677, 697 (2006), this Court observed that FEHBA's preemption provision was "open to more than one construction." Based on *McVeigh*, the Missouri Court determined that it had the duty to accept a reading that disfavored preemption. Pet. App. 49a. The Court further noted that this Court had distinguished between an insured's insurance coverage and benefits and the insurer's right to subrogation. With these considerations and *McVeigh*'s "cautious" reading of FEHBA's preemption provision, the Missouri Supreme Court determined that FEHBA did not preempt Missouri law barring subrogation. Pet. App. 53a-54a. The court reasoned that the FEHBA contract's subrogation provision did not relate to "coverage and benefits" but only to the insurer's right to reimbursement after benefits have been provided. *Id.*

Coventry petitioned for certiorari. While that petition was pending, OPM adopted a new regulation stating that subrogation and reimbursement under a FEHBA contract "relate to" benefits and that those provisions were "therefore effective notwithstanding any state or local law" or regulation. 5 C.F.R. § 890.106(h). This Court granted certiorari, vacated the Missouri Supreme Court's judgment, and remanded for reconsideration in light of OPM's new rule. *Coventry Health Care of Missouri, Inc. v. Nevils*, 135 S. Ct. 2886 (2015).

On remand, the Missouri Supreme Court reaffirmed its determination that FEHBA did not preempt the state's anti-subrogation law. The Court noted that OPM's rule had done nothing to change the text of FEHBA's preemption provision, and it declined to apply deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), to OPM's new rule. Pet. App. 5a. The Court reasoned that, "[w]hile *Chevron* has been applied repeatedly to determine the substantive meaning of a statute, the United States Supreme Court has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause." *Id.* The Court further reasoned that Coventry's contention that it should defer to the OPM rule amounted to a "tacit admission" that Congress had not expressed a "clear and manifest intent" to preempt state anti-subrogation laws. Pet. App. 7a. Given the ambiguity of FEHBA's preemption clause, the Court again applied a presumption against preemption. *Id.*

The Court also found guidance from this Court's decision in *Smiley v. Citibank (S. Dakota), N.A.*, 517

U.S. 735 (1996). There, this Court rejected the argument that an agency rule was not entitled to deference and that the presumption against preemption should apply, stating that the argument confused "the question of the substantive (as opposed to pre-emptive) *meaning* of a statute with the question of *whether* a statute is pre-emptive. We may assume (without deciding) that the latter question must always be decided de novo by the courts." *Smiley*, 517 U.S. at 744. The Missouri Court read *Smiley* as indicating that *Chevron* deference applies to an agency's determinations about substantive provisions but that deference does not extend to provisions "that deal expressly with preemption[.]" Pet. App. 9a. The court thus held that OPM's rule did not change the fact that FEHBA's preemption provision did not "express Congress' clear and manifest intent to preempt Missouri's anti-subrogation law." Pet. App. 13a.

SUMMARY OF THE ARGUMENT

I. For an agency to be entitled to *Chevron* deference, the agency must act within the authority that Congress has delegated to the agency. This basic principle applies to an agency's ability to make preemption determinations. If Congress has not delegated an agency the authority to make preemption determinations, then an agency's attempt to do so—even through a rulemaking process—is invalid, and the agency's preemption determination is not entitled to *Chevron* deference.

In some instances, including in the health insurance context, Congress has expressly delegated to an agency the authority to preempt state law, but it did not do so here. Because Congress did not delegate to OPM the

authority to decide for itself whether FEHBA or OPM's regulations preempt state law, OPM's rule, which attempts to displace state law, is invalid. That OPM enacted its rule following notice-and-comment rulemaking is of no consequence because an agency cannot confer more authority on itself than what Congress has conferred.

A general delegation of rulemaking authority does not authorize an agency to make preemption determinations that are entitled to *Chevron* deference. First, a principal reason given for deferring to agency determinations is that agencies may possess expertise in the areas that they regulate. But agencies possess no special knowledge concerning the sensitive federalism balance at issue in preemption questions. In fact, they are typically indifferent to those concerns. Second, state interests are represented in Congress so state autonomy finds some protection inherent in the political process. Agencies, however, are not designed to represent state interests, and may even be biased in favor of exclusive federal control. In short, allowing an agency to make preemption determinations based on a general delegation of authority threatens to disrupt the delicate balance of dual sovereignty.

II. In cases involving preemption of state law, this Court has adopted a presumption against preemption out of respect for the States as independent sovereigns and to ensure that state laws are not cavalierly displaced. Similarly, when a preemption provision is susceptible to multiple interpretations, this Court has adopted statutory readings that disfavor preemption. While federal laws can preempt state laws under the Supremacy Clause, the States maintain a strong

interest in enforcing all laws that have not been preempted. Thus, the States believe that a presumption against preemption should apply in all preemption cases. A presumption against preemption should certainly apply here because this case involves a preemption provision that this Court has already recognized is susceptible to more than one interpretation. The States ask this Court to reaffirm that, when faced with an ambiguous preemption clause, courts should adopt an interpretation that avoids preemption.

ARGUMENT

I. OPM's Rule Is Not Entitled To *Chevron* Deference Because Congress Did Not Grant OPM The Authority To Make Preemptive Determinations.

A federal agency's assertion that state laws are preempted implicates foundational federalism and separation-of-power concerns. The answer to these concerns is that an agency lacks the authority to declare the preemptive scope of a federal statute unless Congress expressly delegated that power to the agency. Because Congress did not delegate that power to OPM, 5 C.F.R. § 890.106(h) is invalid.

1. The United States Constitution "establishes a system of dual sovereignty between the States and the Federal Government." *Gregory*, 501 U.S. at 457. Under this federal system, the States have sovereign authority concurrent with the federal government's authority. *Id.* This "'constitutionally mandated balance of power' between the States and the Federal Government was adopted by the Framers to ensure the

protection of 'our fundamental liberties'"; the federalist system operates as a check on government abuses of power. *Id.* at 458 (quoting *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 242 (1985)). Further, joint sovereignty provides numerous advantages to the people: "It assures a decentralized government that will be more sensitive to the diverse needs of a heterogeneous society; it increases opportunity for citizen involvement in democratic processes; it allows for more innovation and experimentation in government; and it makes government more responsive by putting the States in competition for a mobile citizenry." *Gregory*, 501 U.S. at 458.

Under this system, the States retain "substantial" authority as sovereigns, which is limited only by the Supremacy Clause. *Id.* at 457. Under the Supremacy Clause, "state law that conflicts with federal law is without effect" and is preempted. *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992) (internal quotation and citation omitted). Additionally, this Court has determined that an agency regulation with the force of law can preempt state law. *See Wyeth v. Levine*, 555 U.S. 555, 576 (2009). However, the only authority that an agency has is the authority Congress delegates, and when an agency goes beyond the power that Congress has conferred, the agency's actions are invalid. *See City of Arlington v. FCC*, 133 S. Ct. 1863, 1869 (2013) (when agencies act improperly or without jurisdiction, their actions are "ultra vires"). This limit on agency authority extends to the preemption context because "an agency literally has no power to act, let alone pre-empt the validly enacted legislation of a sovereign State, unless and until Congress confers power upon it." *New York v. FERC*, 535 U.S. 1, 18

(2002) (quoting *Louisiana Public Service Commn. v. FCC*, 476 U.S. 355, 374 (1986)). Thus, the "question a court faces when confronted with an agency's interpretation of a statute it administers is always, simply, *whether the agency has stayed within the bounds of its statutory authority*." *City of Arlington*, 133 S. Ct. at 1868 (emphasis in original).

If an agency is acting outside the bounds of its statutory authority, then its actions are not entitled to deference. As this Court has recognized, a "precondition to deference under *Chevron* is a congressional delegation of administrative authority." *Adams Fruit Co. v. Barrett*, 494 U.S. 638, 649 (1990). Further, "it is fundamental 'that an agency may not bootstrap itself into an area in which it has no jurisdiction.'" *Id.* at 650 (quoting *Federal Maritime Commn. v. Seatrain Lines, Inc.*, 411 U.S. 726, 745 (1973).

2. OPM acted outside its authority when it adopted 5 C.F.R. § 890.106(h). Neither FEHBA's general grant of rulemaking authority to OPM nor its express preemption provision specifically delegate to OPM the authority to determine when FEHBA preempts state law. The preemption provision provides only that contract terms relating to coverage or benefits "shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). This language establishes that contract terms that "relate to" coverage or benefits preempt state law, but it does not go the next step and authorize OPM to itself preempt state law.

And Congress did not separately delegate to OPM the power to determine when FEHBA preempts state laws, either as a matter of conflict preemption or under the preemption provision. The absence of such specific delegation is significant because, while agencies may have "a unique understanding of the statutes they administer," they "have no special authority to pronounce on pre-emption absent delegation by Congress." *Wyeth*, 555 U.S. at 577. And Congress has been clear when it has expressly authorized agencies to preempt state law in other instances. *Wyeth* provided three examples. *See* 555 U.S. at 576 n.9. Regarding telecommunications, Congress expressly authorizes the FCC to make preemption determinations: the FCC "shall preempt the enforcement" of state and local laws if, "after notice and an opportunity for public comment, the Commission determines that a State or local government has permitted or imposed any statute, regulation, or legal requirement that" prohibits or has the "effect of prohibiting the ability of any entity to provide any interstate or intrastate telecommunications service." 47 U.S.C. § 253(a), (d). In mining and reclamation, Congress has authorized the Secretary of Interior to "set forth any State law or regulation which is preempted and superseded by the Federal program." 30 U.S.C. § 1254(g). And, in regulating the transportation of hazardous materials, Congress included an express preemption provision and also set forth the process for the Secretary of Transportation to decide whether federal law preempts a state or tribal law. 49 U.S.C. § 5125(d).

But these are not the only examples of congressional delegation of preemption authority. Regarding commercial motor vehicle safety, a "State

may not enforce a State law or regulation on commercial motor vehicle safety that the Secretary of Transportation decides under this section may not be enforced." 49 U.S.C. § 31141(a). Congress has expressly authorized the Comptroller of the Currency to preempt state consumer financial laws. 12 U.S.C. § 25b ("preemption determination under this subparagraph may be made by a court, or by regulation or order of the Comptroller of the Currency"). And Congress has provided the Federal Insurance Office express authority "to determine . . . whether State insurance measures are preempted[.]" 31 U.S.C. § 313(c), (f).

Most relevant to this case, Congress has included similar authorizations in the context of health insurance. For example, regarding contracts for military medical and dental care, Congress has expressly delegated to the Secretary of Defense the authority to decide whether state laws are preempted. 10 U.S.C. § 1103(a). That statutory authorization provides that a state law "relating to health insurance, prepaid health plans, or other health care delivery or financing methods shall not apply" to health care contracts entered into by the Secretary of Defense "to the extent that the Secretary of Defense or the administering Secretaries determine that" the state law is inconsistent with a specific contract provision or defense regulation or "to the extent" that the Secretary of Defense determines that "the preemption of the State or local law or regulation is necessary to implement or administer the provisions of the contract or to achieve any other important Federal interest." 10 U.S.C. § 1103(a).

As these provisions show, when Congress intends to authorize an agency to directly preempt state laws, it knows how to do so. It did not do so here, and Congress's decision *not* to expressly authorize OPM to preempt state law should be given great weight. Indeed, this Court has routinely deferred to congressional silence where Congress has expressly spoken on a particular issue in other statutes. *See, e.g.*, *Whitfield v. United States*, 543 U.S. 209, 216-217 (2005) ("Congress has included an express overt-act requirement in at least 22 other current conspiracy statutes, clearly demonstrating that it knows how to impose such a requirement when it wishes to do so . . . . Where Congress has chosen *not* to do so, we will not override that choice. . . ."); *Dole Food Co. v. Patrickson*, 538 U.S. 468, 476 (2003) ("Where Congress intends to refer to ownership in other than the formal sense, it knows how to do so. Various federal statutes refer to direct and indirect ownership. The absence of this language in 28 U.S.C. § 1603(b) instructs us that Congress did not intend to disregard structural ownership rules.") (internal citations omitted); *Gwaltney of Smithfield, Ltd. v. Chesapeake Bay Foundation, Inc.*, 484 U.S. 49, 57 (1987) ("Congress has demonstrated in . . . other statutory provisions that it knows how to avoid this prospective implication by using language that explicitly targets wholly past violations."); see also *Watters v. Wachovia Bank, N.A.*, 550 U.S. 1, 38 (2007) (Stevens, J., dissenting) ("To begin with, Congress knows how to authorize executive agencies to pre-empt state laws. It has not done so here.") (Internal footnote omitted).

Similarly, "where Congress includes particular language in one section of a statute but omits it in

another section of the same Act, it is generally presumed that Congress acts intentionally and purposefully in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23 (1983) (internal quotation marks and citations omitted). Although this principle speaks to the "inclusion or exclusion" within a statute, its logic also applies when comparing statutes. When Congress expressly delegates the authority and the process for agencies to make preemption determinations, and then does not include such delegation in other statutes, like FEHBA, this Court should presume that Congress "act[ed] intentionally and purposefully" in not delegating that authority.

3. In arguing to the contrary, Coventry and the United States assert that the general rulemaking authority of 5 U.S.C. § 8913(a) authorizes OPM to use rulemaking to preempt state laws. *See* Pet. Br. at 42; U.S. Br. at 22. But a mere general delegation of authority does "not include the authority to decide the pre-emptive scope of a federal statute." *Gonzales v. Oregon*, 546 U.S. 243, 263 (2006) (citing *Adams Fruit Co.*, 494 U.S. at 649-50). As just discussed, Congress's specific delegation of preemptive power in various other statutes creates a powerful inference that Congress did not wish to delegate that power in statutes—such as FEHBA—which lack such a specific delegation of power.

Many additional reasons support the proposition that a general delegation of rulemaking authority does not authorize an agency to make preemption determinations that are entitled to *Chevron* deference. First, the reasons that courts defer to agency

determination are not present in the preemption context. One of the "principal justifications" underlying *Chevron* deference is an agency's practical expertise. *Pension Benefit Guaranty Corp. v. LTV Corp.*, 496 U.S. 633, 651-52 (1990). But while an agency may possess unique knowledge in the area it regulates, preemption questions necessarily encompass larger questions involving federalism-type values and state autonomy, which are areas where agencies generally lack any expertise. *See e.g.*, Thomas W. Merrill, *Symposium: Ordering State-Federal Relations Through Federal Preemption Doctrine: Preemption and Institutional Choice*, 102 Nw. U.L. Rev. 727, 755 (2008) (observing the "critical problem here is one of tunnel vision. Agencies know a great deal about one federal regulatory scheme, . . . But they are unlikely to have much knowledge—or even care—about larger questions concerning the division of authority between the federal government and the states."). Because agencies have no practical "expertise" in these areas, there is no reason that courts should accord them any deference when they make preemption determinations. *See also*, Ernest A. Young, *Symposium: Ordering State-Federal Relations Through Federal Preemption Doctrine: Executive Preemption*, 102 Nw. U.L. Rev. 869, 886-89 (2008) (explaining that the usual justifications for *Chevron* deference are problematic or impracticable in the preemption context).

Second, deferring to an agency's preemption determinations when it has no express preemptive authority threatens the autonomy that States possess in our system of dual sovereignty. As this Court has recognized, the political process provides the primary safeguard for protecting state autonomy. *See Gregory*,

501 U.S. at 464 (noting that the "Court in *Garcia* [*v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985)] has left primarily to the political process the protection of the States against intrusive exercises of Congress' Commerce Clause powers"). States' interests have some protection through their representation in Congress. State autonomy also finds some protection in the inherent inertia present in the legislative enactment process. *See* Young, *Executive Preemption*, 102 Nw. L. Rev. at 876. Federal agency action provides neither of these protections, and agencies can easily sidestep them. As Professor Young correctly notes, agencies "have no mandate to represent state interests and possess strong countervailing incentives to maximize their own power and jurisdiction." *Id.* at 878. Justice Stevens similarly observed that, "Unlike Congress, administrative agencies are clearly not designed to represent the interests of States, yet with relative ease they can promulgate comprehensive and detailed regulations that have broad pre-emption ramifications for state law." *Geier v. American Honda Motor Company, Inc.*, 529 U.S. 861, 908 (2000) (Stevens, J., dissenting).

In addition to not representing state interests, there are also the related dangers that an agency will be biased in favor of exclusive federal control and that the agency will be "captured by the firms it regulates." Merrill, *Preemption and Institutional Choice*, 102 Nw. U.L. Rev. at 756. Significantly, allowing an agency to preempt state law under a general delegation of authority "could result in an agency possessing the authority to preempt nearly any relevant state law that makes a policy choice different from that made by the agency." Nina A. Mendelson, *Symposium: Ordering*

State-Federal Relations Through Federal Preemption Doctrine: A Presumption Against Agency Preemption, 102 Nw. U.L. Rev. 695, 710 (2008). Congress should not be presumed to have given an agency such sweeping power through a delegation of general rulemaking authority. *Id.* at 716.

The fact that OPM made its preemption determination pursuant to notice-and-comment rulemaking does not change the analysis. While Congress has authorized some agencies to make preemptive determinations after notice-and-comment, *e.g.*, 47 U.S.C. § 253(d), it has not given OPM that authority. An agency cannot "bootstrap" itself into more power than Congress conferred upon it simply by cloaking its actions in the administrative process. *See Adams Fruit Co.*, 494 U.S. at 650.

4. This Court should also reject Coventry's characterization of OPM's rulemaking as simply interpreting a substantive provision. Coventry Br. at 47-50; *also* U.S. Br. at 21-23. Even OPM acknowledged it was making a preemption determination. *See* 5 C.F.R. § 890.106(h). OPM's regulation makes no secret that it intended to declare the preemptive scope of FEHBA; after stating that an insurance carrier's rights to subrogation and reimbursement "relate to" coverage and benefits, OPM stated: "These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans." *Id.* The plain language of OPM's rule makes clear that OPM was going far beyond merely interpreting a substantive provision and was instead making a preemption determination.

For similar reasons, Coventry misplaces its reliance on *Smiley v. Citibank (South Dakota), N.A.*, 517 U.S. 735 (1996). *Smiley* recognized a distinction between an agency's authority to interpret a statute's substantive meaning and an agency's authority to decide whether a statute preempted state law. *Id.* at 744. *Smiley* assumed, albeit without deciding, that whereas agencies could interpret substantive statutory meaning, whether a statute was preemptive was a job for the courts. *Id.* If Coventry's view of *Smiley* is correct, then the distinction between substantive and preemptive regulations that *Smiley* assumed existed is illusory. Agencies can simply announce an "interpretation" of a statute and then declare that, based on its interpretation, its rule is "therefore effective notwithstanding any state or local law, or any regulation issued thereunder[.]" 5 C.F.R. § 890.106(h). If agencies are permitted to confer power upon themselves in this way, then no state law is safe from preemption, regardless of Congress's intent.

II. The Presumption Against Preemption Applies When Interpreting The Scope Of An Express Preemption Provision.

1. Because preemption implicates federalism concerns and the States' sovereign responsibility to ensure the public health and safety of their citizens, this Court has adopted guiding principles to ensure that state laws are not cavalierly preempted. First, Congress's purpose is the "touchstone" in a preemption analysis. *Cipollone*, 505 U.S. at 516; *accord Altria Group Inc. v. Good*, 555 U.S. 70, 76 (2008). Second, this Court assumes that Congress did not intend to preempt state law unless that is Congress's "clear and

manifest purpose." *Cipollone*, 505 U.S. at 516; *accord Altria Group Inc.*, 555 U.S. at 77. Additionally, when an express preemption provision is susceptible to more than one meaning, one that favors preemption and one that disfavors preemption, this Court accepts the meaning that disfavors preemption. *Altria Group Inc.*, 555 U.S. at 77 (citing *Bates v. Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005)).

This Court has employed the presumption against preemption for sixty years. *See Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). The principle underlying the presumption is the Court's "respect for the States as 'independent sovereigns in our federal system.'" *Wyeth*, 555 U.S. at 565 n.3 (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996)). The Court applies the presumption both out of concern for federalism and the States' historical "primacy" in regulating for health and safety. *Medtronic*, 518 U.S. at 485. The presumption also reflects the principle that "'[t]o give the state-displacing weight of federal law to mere congressional *ambiguity* would evade the very procedure for lawmaking on which *Garcia* relied to protect states' interests.' L. Tribe, American Constitutional Law § 6-25, p. 480 (2d ed. 1988)." *Gregory*, 501 U.S. at 464.

The Court has applied the presumption when addressing either express or implied preemption as well as the scope of preemption. *Altria Group, Inc.*, 555 U.S. at 77; *Medtronic*, 518 U.S. at 485. In light of these precedents, the Missouri Supreme Court properly applied the presumption against preemption to analyze FEHBA's ambiguous preemption clause.

2. Citing *Puerto Rico v. Franklin California Tax-Free Trust*, 136 S. Ct. 1938, 1946 (2016), Coventry argues that no presumption against preemption should apply when an express preemption clause is at issue and that Congress's preemptive scope should be discerned by focusing solely on the statutory text. *E.g.*, Coventry Br. at 36. That reasoning makes sense only when the preemption clause, as a matter of plain meaning, clearly applies in a given context. After all, if—as in *Franklin California Tax-Free Trust*—it is "clear and manifest" from the statute which state laws Congress intended to preempt, then there may be no need to employ other interpretive tools. But when the provision's language does not clearly resolve whether it applies, the presumption has a critical role to play.

As this Court has recognized, "Congress' enactment of a provision defining the pre-emptive reach of a statute implies that matters beyond that reach are not pre-empted." *Cipollone*, 505 U.S. at 517. Stated differently, a statute that expresses Congress's "clear and manifest" purpose to preempt some laws equally expresses Congress's "clear and manifest" intent not to preempt others. Given the States' interests in enforcing their police powers and statutes that have not been preempted, a presumption against preemption should apply when determining the scope of an express preemption clause. As Professor Young has noted, "[i]t is unclear why the presumption against preemption should 'dissolve' . . . when we move from the first question to the second—that is, why the same concerns for state autonomy that raise the interpretive bar to find *any* preemption should not also weigh against interpreting the *scope* of preemption too broadly." Ernest A. Young, *Article: "The Ordinary Diet of the*

Law": The Presumption Against Preemption in the Roberts Court, 2011 Sup. Ct. Rev. 253, 272.

No one suggests that the presumption against preemption should apply *instead of* or to the exclusion of the statutory text. But it is wrong to assume that an express preemption clause is at odds with this Court's assumption that Congress does not intend to displace state law unless that is its clear and manifest intent. Rather, the presumption and the statutory text work together. For example, in *Cipollone*, the Court applied the presumption against preemption in conjunction with its interpretation of the statutory text. *See Cipollone*, 505 U.S. at 518, 522-23. Moreover, given that the courts have applied a presumption against preemption for six decades, it is reasonable to assume that Congress enacts legislation, including preemption provisions, with the understanding that courts will apply the presumption and if Congress wishes to make its intentions clear, it can do so. *See* Mendelson, *A Presumption Against Agency Preemption*, 102 N.w. U.L. Rev. at 708 ("Congress drafts legislation against the backdrop of the presumption against preemption, which has been a well-established canon of construction in judicial opinions for several decades. It is reasonable to think that legislative drafters would be aware of and attentive to the operation of such a canon.").

When the text of a preemption clause is ambiguous, Congress's intent is, by definition, not clear. In these instances, statutory text is not enough, and the Court must use other interpretive tools. With an ambiguous preemptive clause, it makes perfect sense to apply a presumption against preemption because the reason for

not applying the presumption—that Congress's intent is clear and manifest—is inapplicable. When the reach of a preemption provision is ambiguous, the presumption against preemption aids courts in drawing the line in a way that honors federalism principles and respects the sovereignty that the States share with the federal government. That is why, "when the text of a pre-emption clause is susceptible of more than one plausible reading, courts ordinarily 'accept the reading that disfavors pre-emption.'" *Altria Group Inc.*, 555 U.S. at 77 (quoting *Bates*, 544 U.S. at 449).

3. This Court has already decided that FEHBA's preemption clause is ambiguous, and thus, it should interpret it in a manner that disfavors preemption. *Altria Group Inc.*, 555 U.S. at 77. In *McVeigh*, this Court observed that 5 U.S.C. § 8902(m)(1) was "a puzzling measure, open to more than one construction." 547 U.S. at 697. What is more, this Court made that statement in the context of a health insurance contract's reimbursement provision, the same type of provision at issue here. The Court noted that the reimbursement provision could be interpreted as a contract term that related to "coverage or benefits," in which case the provision would fall within the scope of FEHBA's preemption clause. *Id.* However, because a reimbursement claim typically comes "long after 'coverage' and 'benefits' questions have been resolved," the preemption provision could also be read as referring to the beneficiary's right to payment under the plan and not to the carrier's right to reimbursement. *Id.* The Court did not have to "choose between those plausible constructions" to decide the issue in *McVeigh*, but the highlighted ambiguity exists nonetheless. *Id.*

In light of this Court's discussion in *McVeigh*, Coventry's assertion that FEHBA's preemption "statute speaks clearly" is mystifying. *See* Coventry Br. at 39. This Court has already said that the statute is "open to more than one construction," *McVeigh*, 547 U.S. at 697, and thus, it does not speak clearly. Coventry tries to fight this obvious conclusion by characterizing the Court's discussion as "dictum" and pointing out that the holding regarding jurisdiction was decided "[o]ver the dissent of four justices." Coventry Br. at 39-40. First, a decision "over the dissent of four justices" is a majority opinion and it is entitled to the same weight as any other majority opinion. Second, whether the majority's determination was dictum or not does not change that the Court found FEHBA's preemption provision ambiguous.

Because FEHBA's preemption provision is susceptible to more than one interpretation, courts should interpret FEHBA's preemption clause in a way that disfavors preemption. *Altria Group Inc.*, 555 U.S. at 77. The statute, properly construed, does not preempt Missouri's anti-subrogation law; and, as shown in § I, *supra*, OPM lacked the authority to adopt a rule saying otherwise. The Missouri Supreme Court was therefore correct both times it addressed this case.

CONCLUSION

This Court should affirm the judgment below.

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Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ of Certiorari to the Supreme Court of Missouri

BRIEF OF *AMICI CURIAE* NATIONAL GOVERNORS ASSOCIATION AND OTHER STATE AND LOCAL ORGANIZATIONS IN SUPPORT OF RESPONDENT

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INTEREST OF THE *AMICI CURIAE*[1]

The National Governors Association (NGA), founded in 1908, is the collective voice of the nation's governors. NGA's members are the governors of the 50 States, three Territories, and two Commonwealths.

The National Conference of State Legislatures (NCSL) is a bipartisan organization that serves the legislators and staffs of the nation's 50 States, its Commonwealths, and Territories. NCSL provides research, technical assistance, and opportunities for policymakers to exchange ideas on the most pressing state issues. NCSL advocates for the interests of state governments before Congress and federal agencies, and regularly submits *amicus* briefs to this Court in cases, like this one, that raise issues of vital state concern.

The Council of State Governments (CSG) is the nation's only organization serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy. This offers unparalleled regional, national, and international opportunities to network, develop leaders,

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1. All parties have consented to the filing of this brief (Rule 37.2). This brief was not written in whole or in part by the parties' counsel, and no one other than the *amici* made a monetary contribution to its preparation (Rule 37.6).

collaborate, and create problem-solving partnerships.

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo provides essential services to the nation's 3,069 counties through advocacy, education, and research.

The National League of Cities (NLC) is dedicated to helping city leaders build better communities. NLC is a resource and advocate for 19,000 cities, towns and villages, representing more than 218 million Americans.

The U.S. Conference of Mayors (USCM), founded in 1932, is the official nonpartisan organization of all United States cities with a population of more than 30,000 people, which includes over 1,200 cities at present. Each city is represented in USCM by its chief elected official, the mayor.

The International City/County Management Association (ICMA) is a nonprofit professional and educational organization consisting of more than 11,000 appointed chief executives and assistants serving cities, counties, towns, and regional entities. ICMA's mission is to create excellence in local governance by advocating and developing the professional management of local governments throughout the world.

All state and local governments have a vital interest in the scope of federal regulatory authority. Often an expansion of federal authority means a restriction of state and local authority. If courts defer to federal agencies' determinations of the preemptory effect of statutes they administer, the scope of federal authority will expand—perhaps dramatically—and state and local authority will recede. *Amici* advocate the interests of state and local governments and their role in a productive partnership with the federal government. *Amici* thus have a strong interest in the outcome of this case.

SUMMARY OF ARGUMENT

The Constitution reserves to the states and to the people those "powers not delegated to the United States by the Constitution, nor prohibited by it to the States." U.S. Const. amend. X. Today, federal agencies wield more power than ever and regulate many aspects of our daily lives, including in areas committed to the states. Agencies, however, have no power to act without a delegation of authority from Congress. Protecting our federalist system depends on judicial review of agency action to ensure that agencies are not exceeding their congressionally delegated authority at the expense of the states. The federal courts' ability to uphold the Constitution's respect for the sovereignty of the states is jeopardized if agencies have the broad power to issue preemptive interpretations of federal law to which courts must defer under *Chevron, U.S.A., Inc. v.*

Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).

As a general proposition, separation-of-powers principles dictate that *Chevron* deference applies only when Congress delegated to an agency the authority to interpret with the force of law. This Court's cases make clear that the question of whether Congress has authorized an agency to provide an interpretation of a statute that carries the force of law is for the courts alone to decide. The appropriate inquiry is whether Congress delegated to the agency the authority to interpret the specific statutory ambiguity.

Agency interpretations that preempt state law raise questions not only about the separation of powers among the federal branches, but also about the appropriate balance of power between state and federal governments. A federal agency's interpretation that a statute displaces state law through preemption implicates complex questions of federalism, and thus it is especially important that the Judicial Branch exercise its constitutional authority to review agency action. Whereas agencies are specialized institutions focused on achieving their narrow regulatory objectives—often insensitive to the specific concerns of state and local governments—courts are far better suited to resolve these questions of constitutional federalism with a broad and unbiased focus.

Perhaps for this reason, Congress has directly and unequivocally authorized agencies to determine the scope of an express preemption clause when it wants agencies (and not the courts) to do so. Absent such an express and specific delegation of authority to a federal agency to issue preemptive regulations, the courts should decide the extent to which a federal law preempts a state law, giving due consideration to the powers reserved to the states. In cases like this one, involving an ambiguity in an express preemption provision, courts should not recognize an implied delegation of preemptive authority to the agency. To divine congressional intent, the courts should construe ambiguities in, or define the scope of, express preemption provisions.

ARGUMENT

I. SEPARATION-OF-POWERS PRINCIPLES PERMIT *CHEVRON* DEFERENCE ONLY WHEN CONGRESS HAS DELEGATED TO AN AGENCY THE AUTHORITY TO INTERPRET WITH THE FORCE OF LAW.

A. Judicial Review Ensures That Agencies Act Within Their Congressionally Delegated Authority.

An Executive Branch agency "may not confer power upon itself." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986). Whatever power agencies have to regulate is derived solely from delegations of authority from Congress. "[A]n agency literally has no power to act, let alone pre-empt the validly

enacted legislation of a sovereign State, unless and until Congress confers power upon it." *Id.* This Court has repeatedly affirmed the bedrock principle that administrative bodies have no inherent authority to act with the force of law. *See, e.g., FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 161 (2000) ("[A]n administrative agency's power to regulate in the public interest must always be grounded in a valid grant of authority from Congress."); *see also FERC v. Elec. Power Supply Ass'n*, 136 S. Ct. 760, 775 (2016) ("FERC cannot take an action transgressing" the limits of its delegated authority to regulate wholesale prices.). As the Court put it in *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979), the "legislative power of the United States is vested in the Congress, and the exercise of quasi-legislative authority by governmental departments and agencies must be rooted in a grant of such power by the Congress and subject to limitations which that body imposes."

For nearly a century, the federal administrative state has proliferated in breadth and scope to assist in meeting the varied challenges of an increasingly complex world. Perhaps as a direct result of its expanded regulatory activity, the so-called fourth branch of government has enjoyed considerable independence. *E.g.*, Elena Kagan, *Presidential Administration*, 114 Harv. L. Rev. 2245, 2250 (2001) ("Of course, presidential control did not show itself in all, or even all important, regulation; no President (or his executive office staff) could, and

presumably none would wish to, supervise so broad a swath of regulatory activity."). The growth of the administrative state, "which now wields vast power and touches almost every aspect of daily life, heightens the concern that it may slip from the Executive's control, and thus from that of the people." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 499 (2010). Preventing unfounded agency assertions of congressionally delegated authority is thus now more important than ever.

Under our separation-of-powers tradition, the Judicial Branch reviews agency action to ensure that agencies do not exceed the limits of their lawfully delegated authority. Congress has long endorsed judicial review of agency action. Most notably, Congress enacted the Administrative Procedure Act (APA), which provides that "[t]he reviewing court shall—. . . (2) hold unlawful and set aside agency action, findings, and conclusions found to be—. . . (C) *in excess of statutory jurisdiction, authority, or limitations, or short of statutory right*[.]" 5 U.S.C. § 706(2)(C) (emphasis added). In section 706(2)(C), Congress expressed its general intent that courts should exercise independent judgment to enforce limits on delegated agency authority.

B. *Chevron* Deference Is Permissible Only When Authorized By Congress.

In *Chevron*, this Court embraced the principle that Congress often intends for federal agencies to

resolve the highly technical policy disputes that lurk beneath ambiguous provisions of the federal statutes that agencies are charged with administering. The logic underlying *Chevron* is that it is appropriate, indeed necessary, in certain circumstances, for courts to defer to an agency's policy expertise to fill in legislative gaps. 467 U.S. at 865-66.

The Court has also made clear that deference under *Chevron* must be considered in light of the critical role that independent judicial review plays in assuring that federal agencies do not exceed the limits of their delegated authority. The *Chevron* Court justified its rule of deference by observing that "an agency to which Congress has delegated policy-making responsibilities may, within the limits of that delegation, properly rely on the incumbent administration's views of wise policy to inform its judgments." *Id.* at 865. This presupposes that judicial deference to an agency's pronouncement on what a federal law means follows only after the judiciary has independently satisfied itself that the agency is acting within the scope of its authority. *See, e.g., Gonzales v. Oregon*, 546 U.S. 243, 258 (2006) ("To begin with, the rule must be promulgated pursuant to authority Congress has delegated to the [agency]."). Put differently, a "precondition to deference under *Chevron* is a congressional delegation of administrative authority." *Adams Fruit Co. v. Barrett*, 494 U.S. 638, 649 (1990) (citing cases).

Thus, an agency's interpretation of federal law

is not entitled to deference "merely because the statute is ambiguous and an administrative official is involved." *Gonzales*, 546 U.S. at 258 (declining to apply *Chevron* deference to agency's interpretation). Instead, courts afford *Chevron* deference to an agency's interpretation of a statutory ambiguity only after determining, independently, that Congress intended such an interpretation to carry the force of law. *United States v. Mead Corp.*, 533 U.S. 218, 221 (2001).[2] "Courts have never deferred to agencies with respect to questions such as whether Congress has delegated to an agency the power to act with the force of law . . . ." Thomas W. Merrill & Kristen E. Hickman, Chevron*'s Domain*, 89 Geo. L.J. 833, 910 (2001).

Congress may explicitly or implicitly delegate authority to an agency to fill in a statutory gap or interpret a statutory ambiguity based on the agency's views of "wise policy." *See Mead*, 533 U.S. at 229; *Chevron*, 467 U.S. at 844. If Congress has explicitly delegated authority, the judicial inquiry is relatively straightforward. If an agency claims an

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2. *See also City of Arlington v. FCC*, 133 S. Ct. 1863, 1876 (2013) (Breyer, J., concurring) ("The question whether Congress has delegated to an agency the authority to provide an interpretation that carries the force of law is for the judge to answer independently."); *id.* at 1885 (Roberts, C.J., dissenting) ("[B]efore a court can defer to the agency's interpretation of the ambiguous terms [of a statute], it must determine for itself that Congress has delegated authority to the agency to issue those interpretations with the force of law.").

implicit delegation of interpretive authority, however, the courts must ask whether it is "apparent from the agency's generally conferred authority and other statutory circumstances that Congress would expect the agency to be able to speak with the force of law when it addresses ambiguity in the statute or fills a space in the enacted law." *Mead*, 533 U.S. at 229.

To warrant *Chevron* deference, Congress's delegation of authority (whether explicit or implicit) must extend to the specific statutory ambiguity at issue. In *Mead*, this Court framed the issue as whether Congress had delegated to an administrative agency the authority to interpret "a particular statutory provision." *Id.* at 226-27. In *Adams Fruit*, the Court recognized that "Congress clearly envisioned . . . a role for the Department of Labor in administering the statute by requiring the Secretary to promulgate *standards* implementing AWPA's motor vehicle provisions," but concluded that Congress intended no such delegation "regarding AWPA's enforcement provisions." 494 U.S. at 650.[3] "It seems impossible that courts should do anything other than actually examine the full text

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3. *See also City of Arlington*, 133 S. Ct. at 1884 (Roberts, C.J., dissenting) ("When presented with an agency's interpretation of . . . a statute, a court cannot simply ask whether the statute is one that the agency administers; the question is whether authority over *the particular ambiguity at issue* has been delegated to the particular agency.") (emphasis added).

of the statute in order to determine whether the particular grant of authority extends to the contested provision at issue." Thomas W. Merrill, *Step Zero After* City of Arlington, 83 Fordham L. Rev. 753, 781 (2014).

The notion that a court should determine independently whether Congress intended to delegate to an agency the authority to interpret a specific statutory ambiguity, before the court applies *Chevron* deference, is inherent in the language of *Chevron* itself. The Court in *Chevron* asked whether Congress delegated to the Environmental Protection Agency authority "to elucidate a *specific provision* of the statute by regulation," and held that Congress had charged the agency "with responsibility for administering *the provision*." *Chevron*, 467 U.S. at 843-44, 865 (emphasis added). Understanding the *Chevron* doctrine as requiring a specific grant of statutory authority to the agency is consistent with the principle that reviewing courts must exercise independent judgment in determining whether an agency is acting within the scope of its delegated authority.

II. FEDERALISM PRINCIPLES PRECLUDE *CHEVRON* DEFERENCE TO AGENCY INTERPRETATIONS OF PREEMPTIVE PROVISIONS, ABSENT AN EXPRESS DELEGATION TO ISSUE PREEMPTIVE REGULATIONS.

Preemption of state law by federal regulation prompts questions not only about the separation of

powers, but also about the proper federal-state balance. Delegated agency authority to preempt raises a host of issues apart from how to interpret ambiguities or fill gaps in federal law based on agency policy expertise—the core of *Chevron* deference. Due to the additional constitutional concerns that attend preemption of state law, there must be certainty that Congress intended to exercise its power under the Supremacy Clause to grant an agency preemptive power. Unless Congress expressly delegates to an agency the authority to determine the scope of the statute's preemptive effect, courts should decide preemption questions in order to protect the powers reserved to the states.

Independent judicial determination is critical when federal agencies seek to expand their power at the expense of state and local governments. Congress is vested with the ultimate authority to set the boundaries of agency authority in all of these areas, and courts have a duty to assure that the boundaries imposed by Congress are maintained. *See La. Pub. Serv. Comm'n*, 476 U.S. at 374-75 ("To permit an agency to expand its power in the face of a congressional limitation on its jurisdiction would be to grant to the agency power to override Congress. This we are both unwilling and unable to do."). A practice of deferring to agency determinations of the scope of agency authority to preempt state law, absent independent judicial review, would be at odds with the courts' traditional role as a bulwark against

agency overreach. The *Chevron* doctrine does not contemplate such a practice.

A. The Federal Courts Play A Critical Role In Protecting State Sovereignty Against Unauthorized Federal Encroachment.

Federal agencies commonly regulate the same or similar subject matter as state and local governments. Allowing federal agencies to determine the scope of federal preemption, with only highly deferential review by courts, would permit federal agencies to encroach upon the authority of state and local governments in these areas, with little, if any, constraint. As Professor Merrill has observed, "[g]iving *Chevron* deference to agency views about . . . express preemption clauses could result in a persistent expansion of federal authority at the expense of the states[.]" Merrill, *Step Zero After* City of Arlington, *supra*, at 786 (citation omitted). This case vividly illustrates the risk.

A federal agency's interpretation of a statutory ambiguity as preempting state law implicates important questions of federalism. *See Medtronic Inc. v. Lohr*, 518 U.S. 470, 488 (1996). Preemption displaces state governmental authority, eliminating the power of the states to act, often in areas where they have long been understood to exercise exclusive authority. Among these powers are health, safety, and related areas of insurance. *See id.* at 475. From the perspective of the states, there is little difference between a finding that state

law is preempted and a finding that state law is unconstitutional. Both nullify otherwise duly enacted state statutes and common law rules of decision. Both equally subtract from the power the states otherwise enjoy as sovereign entities. The interpretation of the scope of an express preemption clause thus has a critical effect on the balance of federal and state regulatory authority.

The judiciary has unique competence to resolve interpretive questions implicating constitutional federalism. Courts are more likely than agencies to be sensitive to broader constitutional concerns about maintaining the traditional federal-state balance and the historical context that gave rise to those concerns. *See* Merrill, *Step Zero After* City of Arlington, *supra*, at 786. When Congress's preemptive intent is less than clear, this Court has declined to defer to agency actions that raise serious questions of constitutional federalism, and has instead interpreted federal law to protect state sovereignty. *See, e.g.*, *Gonzales*, 546 U.S. at 275; *Solid Waste Agency of N. Cook Cnty. v. U.S. Army Corps of Eng'rs*, 531 U.S. 159, 172-73 (2000). The decision that a statutory provision displaces state law through preemption should be informed by an understanding of which areas of regulation reside with the federal government and which have been traditionally committed to the states as police powers. This decision also should be informed by an understanding of whether constitutional federalism would be jeopardized either

by a determination of concurrent authority or of exclusive federal competence. The judiciary is best suited to divine the balance that Congress intended to strike.

Agencies, on the other hand, are specialized institutions, intensely focused on achieving their narrow regulatory objectives. By design and tradition, they are not expected to ponder larger structural issues such as (i) the relative balance of authority between the federal and state governments, (ii) the importance of preserving state and local autonomy, (iii) the localized needs of the states, (iv) the value of allowing policy to vary in accordance with local conditions, and (v) the systemic advantages of permitting state experimentation with divergent approaches to social problems. *See Gregory v. Ashcroft*, 501 U.S. 452, 458-59 (1991) (summarizing the systemic benefits of federalism). As Justice Stevens noted in dissent in *Watters v. Wachovia Bank, N.A.*, 550 U.S. 1, 41 (2007), joined by Chief Justice Roberts and the late Justice Scalia, "administrative agencies are clearly not designed to represent the interest of States." (citation omitted). Thus, "[e]ven assuming that agencies have a superior understanding of the statutes they are specifically charged with administering, it does not follow that they have much, if any, understanding of constitutional law . . . or federalism." Merrill, *Step Zero After* City of Arlington, *supra*, at 786.

B. The Courts Should Defer To Agency Preemptive Determinations Only When Congress Has Expressly Delegated The Authority To Preempt.

Perhaps for these reasons, when Congress wishes to grant an agency authority to determine the scope of an express preemption provision, it does so in the text of the provision itself. *See Wyeth v. Levine*, 555 U.S. 555, 576 & n.9 (2009) (collecting statutes). For example, Congress specifically mandated that the Federal Communications Commission (FCC) "preempt the enforcement of [a state or local] statute, regulation, or legal requirement" if the agency determines that the state or local law "prohibit[s] the ability of any entity to provide any interstate or intrastate telecommunication service." 47 U.S.C. § 253(a), (d). Similarly, under 30 U.S.C. § 1254(g), Congress clearly delegated to the Secretary of the Interior the power to "set forth any State law or regulation which is preempted and superseded by the Federal program." Likewise, Congress explicitly entrusted to the Secretary of Transportation the authority to decide "whether [a state] requirement" concerning the regulation of hazardous waste transportation "is preempted," and to "prescribe regulations for carrying out" that authority. 49 U.S.C. § 5125(d)(1)-(2). And Congress expressly authorized the Secretary of Health and Human Services to determine whether state requirements related to medical devices are preempted by the Federal Food,

Drug, and Cosmetic Act. *See* 21 U.S.C. § 360k. Congress is capable of speaking clearly, in the text of the express preemption provision itself, when it wants to grant a federal agency the considerable power to displace state law. That is decidedly not the case, however, under 5 U.S.C. § 8902(m).

This Court's decisions reflect the understanding that, absent a direct and unambiguous grant of preemptive authority from Congress to an agency, it is the role of the courts, and not the agency, to independently interpret the preemptive effect of a federal law. In *Wyeth*, for instance, the question before the Court was whether the drug labeling judgments of the Food and Drug Administration (FDA) preempted state common law product liability claims brought under the theory that more robust labeling practices were required to make drugs safe for use. *See* 555 U.S. at 563. In arguing that the state law claims were preempted, the petitioner urged the Court to give *Chevron* deference to an FDA regulation governing the content and format of drug labels, in which the agency declared that "FDA approval of labeling . . . preempts conflicting or contrary State law." *Id.* at 575 (citation omitted). The Court declined to afford *Chevron* deference to the FDA's regulation. *Id.* at 576-77. Instead, the Court conducted its own preemption analysis, in which it gave the "agency's explanation of state law's impact on the federal scheme" whatever "weight" it deserved based on "its

thoroughness, consistency, and persuasiveness." *Id.* at 577.

In determining that *Chevron* deference was not warranted, the *Wyeth* Court explained that "Congress has not authorized the FDA to pre-empt state law directly," and that "agencies have no special authority to pronounce on pre-emption absent delegation by Congress." *Id.* at 576-77. Although the Court acknowledged that an agency's views on preemption may merit consideration when, for example, the subject matter is technical, the Court explained that, "[e]ven in such cases . . . we have not deferred to an agency's *conclusion* that state law is pre-empted." *See id.* at 576. After *Wyeth*, the federal courts of appeals have concluded that "*Chevron* deference does not apply to preemption decisions by federal agencies." *Grosso v. Surface Trans. Bd.*, 804 F.3d 110, 116-17 (1st Cir. 2015) (collecting cases from the Fifth, Eighth, Ninth, Tenth, and Eleventh Circuits). As Justice Stevens stated in his dissent in *Watters*, "when an agency purports to decide the scope of federal pre-emption, a healthy respect for state sovereignty calls for something less than *Chevron* deference." 550 U.S. at 41 (Stevens, J., dissenting).

This Court's decision in *Lohr* is similarly instructive. In that case, the Court addressed the scope of another express preemption clause in the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 360k. *See* 518 U.S. at 495. The statute at issue in *Lohr* (unlike the preemption provision in this case)

expressly delegated to the agency the authority to "determin[e] the scope of [the statute's] pre-emptive effect." *See id.* at 495-96. Even then, this Court reached its own conclusion regarding the domain preempted by the statute. Although the Court's conclusion was "substantially informed" by the FDA's views about the statute's preemptive effect, the Court nevertheless applied something less than *Chevron* deference. *Id.* at 495-96; *see also id.* at 512 (O'Connor, J., concurring) ("Apparently recognizing that *Chevron* deference is unwarranted here, the Court does not admit to deferring to [the FDA's] regulations, but merely permits them to 'infor[m]' the Court's interpretation. It is not certain that an agency regulation determining the pre-emptive effect of *any* federal statute is entitled to deference[.]") (citations omitted).

Petitioner and the Government try to undermine this conclusion by arguing that *City of Arlington* stands for the broad proposition that "[t]his Court has flatly rejected the assertion that *Chevron* applies piecemeal to some topics under a statute but not others." Pet'r Br. at 47; *see* United States Br. at 21-22. They argue that because Congress delegated some *Chevron* authority to the Office of Personnel Management (OPM) by virtue of the general conferral of rulemaking authority in 5 U.S.C. § 8913, Congress necessarily delegated to OPM authority to define the preemptive scope of 5 U.S.C. § 8902(m). This is incorrect. The statutory provision at issue in *City of Arlington* required that

state and local governments act on wireless siting applications "within a reasonable period of time after the request is duly filed." 47 U.S.C. § 332(c)(7)(B)(ii). The issue in that case was whether the FCC's interpretation of the phrase "reasonable period of time" was entitled to *Chevron* deference.

Unlike OPM's interpretation of the express preemption clause in this case, the FCC's interpretation of the phrase "reasonable period of time" did not displace any state law. In reaching its holding that the FCC's interpretation was entitled to *Chevron* deference, the Court observed that "this case has nothing to do with federalism," because "Section 332(c)(7)(B)(ii) explicitly supplants state authority by *requiring* zoning authorities to render a decision 'within a reasonable period of time,' and the meaning of that phrase is indisputably a question of federal law." *City of Arlington*, 133 S. Ct. at 1873. Here, on the other hand, OPM's administrative action has everything to do with federalism: if OPM's interpretation is afforded *Chevron* deference, it would erase Missouri common law prohibiting subrogation of personal injury claims for Missouri residents who work for the federal government. On that view, OPM might decide in the future to displace another state common law doctrine that it (or the insurance carriers providing coverage to federal workers) finds inconvenient. That cannot be what Congress intended in a statute that fails to confer express preemptive authority on the agency.

CONCLUSION

Interpreting the scope of an express preemption clause implicates both separation-of-powers and federalism considerations. Absent a direct congressional delegation of authority to an agency to preempt state law, the judiciary, rather than the agency, is best suited to interpret the law and to discern the appropriate constitutional balance between federal and state authority that Congress intended to strike.

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